

FELRA and UFCW Health Fund: Plan X

Coverage Period: 01/01/2014 - 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual + Family | Plan Type: PPO

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.associated-admin.com or by calling 1-800-638-2972.

Important Questions	Answers	Why this Matters:
<p>What is the overall deductible?</p>	<p><u>Before 3/1/2014:</u> In-Network: \$300 person. Doesn't apply to preventive care, including well child immunization; Hospitalization up to 180 days, Chemotherapy and Radiation up to 25 treatments, or the first \$500 in diabetic benefits. <u>Effective 3/1/2014:</u> In-Network: \$300 person; Doesn't apply to preventive care</p>	<p>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p>
<p>Is there an out-of-pocket limit on my expenses?</p>	<p>Yes. \$4,000 per person for In-Network/Out-of-Network eligible charges. <u>Effective 3/1/2014</u>, there also is a limit of \$12,700 per family for In-Network/Out-of-Network eligible charges.</p>	<p>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p><u>Before 3/1/2014:</u> Premiums, balance billed charges, health care this plan does not cover, prescription drugs, dental and vision benefits, penalties for failure to obtain pre-authorization for services. <u>Effective 3/1/2014:</u> non-essential benefits (in addition to above)</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No.</p>	<p>The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.</p>

Questions: Call 1-800-638-2972 or visit us at www.associated-admin.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-638-2972 to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of in-network providers , see www.carefirst.com or call 800-810-2583 for medical providers, and www.valueoptions.com or call 800-353-3572 for mental health and substance abuse disorders providers	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this Plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services .



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network providers by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Service You May Need	Your Cost if You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014</u> : 20% co-insurance of UCR charges, plus balance billing; <u>Effective 3/1/2014</u> : Not covered	None
	Specialist visit	20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014</u> : 20% co-insurance of UCR charges, plus balance billing; <u>Effective 3/1/2014</u> : Not covered	None
	Other practitioner office visit	20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014</u> : 20% co-insurance of UCR charges, plus balance billing; <u>Effective 3/1/2014</u> : Not covered	Coverage is limited to \$1,000/year for a chiropractor

Common Medical Event	Service You May Need	Your Cost if You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Preventive care, screening, immunization	Before 3/1/2014: No charge for routine lab work, well child exams, immunizations, adult screenings for mammograms, Pap, PSA, adult flu shots and HPV vaccine for females, up to 100% of UCR charges, plus balance billing up to In-Network rate. <u>Effective 3/1/2014:</u> No charge	Before 3/1/2014: No charge for routine lab work, well child exams, immunizations adult screenings for mammograms, Pap, PSA, adult flu shots and HPV vaccine for females, up to 100% of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered	Before 3/1/2014: Well child exams limited to 8 visits through age five. <u>Effective 3/1/2014:</u> None
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance of UCR charges, plus balance billing up to In-Network rate	Not covered	Lab work must be provided through Quest or LabCorp.
	Imaging (CT/PET scans, MRIs)	20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com .	Generic drugs	Giant or Safeway pharmacy: 8% co-insurance; Other In-Network pharmacy: 13% co-insurance	Not covered at non-network pharmacies or Rite Aid, Walmart, Walgreens or CVS	Limited to 34-day supply-retail, 100-day supply for approved maintenance medications; some quantity limits apply
	Brand drugs	Giant or Safeway pharmacy: 8% co-insurance; Other In-Network pharmacy: 13% co-insurance, provided there is no generic equivalent		If generic drug is available, you pay full cost of the brand name drug. Limited to 34-day supply for retail and 100-day supply for approved maintenance medications; some quantity limits apply
	Specialty drugs	13% co-insurance		Certain specialty medications require prior authorization and must be ordered by phone through Accredo Specialty Pharmacy which has an 8% co-insurance rate. Certain specialty drugs (e.g., cancer drugs) may be dispensed directly from physician's ofc.

Common Medical Event	Service You May Need	Your Cost if You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	Pre-certification is required
	Physician/surgeon fees	20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	None
If you need immediate medical attention	Emergency room services	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing up to In-Network rate. <u>Effective 3/1/2014:</u> \$75 copay, then 20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> \$75 copay, then 20% co-insurance of UCR charges, plus balance billing	Certification is required within 24 hours if admitted for emergency hospital admission or you will pay 100% of charges. If treated for a nonemergency, you pay 20% after the deductible. Copay will be waived if admitted to the hospital.
	Emergency medical transportation	<u>Before 3/1/2014:</u> No charge up to \$25, plus balance billing. <u>Effective 3/1/2014:</u> 20% of UCR up to \$25, plus balance billing	<u>Before 3/1/2014:</u> No charge up to \$25, plus balance billing. <u>Effective 3/1/2014:</u> 20% of UCR up to \$25, plus balance billing	None
	Urgent care	20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	<u>Before 3/1/2014:</u> No charge up to 180 days at semi-private room rate, then 20% co-insurance of UCR charges, plus balance billing up to In-Network rate. <u>Effective 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> No charge up to 180 days at semi-private room rate, then 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	Pre-certification is required (or certification within 24 hours for an emergency admission). If not obtained, you will pay 100% of charges
	Physician/surgeon fee	20% co-insurance of UCR charges, balance billing up to In-Network rate	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	

Common Medical Event	Service You May Need	Your Cost if You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance of UCR charges	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	<u>Before 3/1/2014:</u> 1st six in-network visits covered at 100% (for lifetime). <u>Effective 3/1/2014:</u> None
	Mental/Behavioral health inpatient services	<u>Before 3/1/2014:</u> No charge up to 180 days at semi-private room rate, then 20% co-insurance of UCR charges. <u>Effective 3/1/2014:</u> 20% co-insurance of UCR charges.	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	Pre-certification is required (or certification within 24 hours for an emergency admission). If not obtained, you will pay 100% of charges
	Substance use disorder outpatient services	20% co-insurance of UCR charges	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	<u>Before 3/1/2014:</u> 1st 30 in-network visits covered at 100%. <u>Effective 3/1/2014:</u> None
	Substance use disorder inpatient services	<u>Before 3/1/2014:</u> No charge up to 180 days at semi-private room rate, then 20% co-insurance of UCR charges. <u>Effective 3/1/2014:</u> 20% co-insurance of UCR charges.	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	Pre-certification is required (or certification within 24 hours for an emergency admission). If not obtained, you will pay 100% of charges
If you are pregnant	Prenatal and postnatal care	20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	<u>Before 3/1/2014:</u> Dependent children are not covered. <u>Effective 3/1/2014:</u> Dependent children are covered, to the extent required under PPACA.
If you are pregnant	Delivery and all inpatient services	20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	<u>Before 3/1/2014:</u> Dependent children are not covered. <u>Effective 3/1/2014:</u> Dependent children are covered, to the extent required under PPACA.

Common Medical Event	Service You May Need	Your Cost if You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	<u>Before 3/1/2014:</u> No charge up to 180 visits, then 20% co-insurance of UCR charges, plus balance billing up to In-Network rate. <u>Effective 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> No charge up to 180 visits, then 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	Pre-certification is required
	Rehabilitation services	<u>Before 3/1/2014:</u> No charge up to 100% of UCR charges for 30 inpatient days, plus balance billing up to In-Network rate; 20% co-insurance of UCR charges for 60 outpatient visits, plus balance billing up to In-Network rate. <u>Effective 3/1/2014:</u> 20% coinsurance of UCR charges for 30 inpatient days and 60 outpatient visits, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> No charge up to 100% of UCR charges for 30 inpatient days, plus balance billing; 20% co-insurance of UCR charges for 60 outpatient visits, plus balance billing. <u>Effective 3/1/2014:</u> Not covered	Pre-certification is required. Limited to 30 days for inpatient treatment and 60 outpatient visits
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered	None
	Durable medical equipment	20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	Pre-certification is required. Rental payment limited to the purchase cost
	Hospice service	<u>Before 3/1/2014:</u> No charge up to 30 days, then 20% co-insurance of UCR charges, plus balance billing up to In-Network rate. <u>Effective 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing up to In-Network rate	<u>Before 3/1/2014:</u> 20% co-insurance of UCR charges, plus balance billing. <u>Effective 3/1/2014:</u> Not covered.	Pre-certification is required. Day limit is included in 180-day Hospitalization maximum. Must have life expectancy of 6 months or less

Common Medical Event	Service You May Need	Your Cost if You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage is limited to one exam/2 yrs
	Glasses	No charge	Not covered	Coverage is limited to one pair of glasses/2 years, subject to limitations for non-covered frames
	Dental check-up	No charge	Reimbursement up to the In-network covered charges, in certain limited circumstances	Children under age 4 are excluded. Limited to one exam every six months

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for those services.)

- Bariatric surgery
- Chiropractic care (Limited to \$1,000 per year)
- Cosmetic surgery (Limited to reconstructive surgery following mastectomy or resulting from traumatic injury)
- Dental care (Adult) (Limited to one routine exam every six months)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult) (Exams and glasses limited to once every 2 years)
- Weight loss programs (limited coverage of anti-obesity prescription drugs)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-638-2972. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact 1-800-638-2972. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the following consumer assistance programs in the state/district in which you reside: DC Office of the Health Care Ombudsman and Bill of Rights at (877) 685-6391, Maryland Office of the Attorney General Health Education and Advocacy Unit at (877) 261-8807 or <http://www.oag.state.md.us/Consumer.HEAU.htm> and Virginia State Corporation Commission Life & Health Division, Bureau of Insurance at (877) 310-6560 or <http://www.scc.virginia.gov/boi>

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-638-2972.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: **\$7540**
- Plan pays **\$6,120**
- Patient pays **\$1,420**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$300
Co-pays	\$0
Co-insurance	\$970
Limits or exclusions	\$150
Total	\$1,420

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: **\$5,400**
- Plan pays **\$4,340**
- Patient pays **\$1,060**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$300
Co-pays	\$0
Co-insurance	\$680
Limits or exclusions	\$80
Total	\$1,060

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.

- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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