UFCW Richmond Tidewater: Standard Plan

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

Coverage Period:01/01/2013 - 12/31/2013

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.anthem.com or by calling 1-800-638-2972.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $500 per person/$1,000 per family; Out-of-Network: $2,000 per person/$4,000 per family. Balance billing, prescription drugs, vision, dental and excluded services do not count toward the deductible.	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.
Are there other deductibles for specific services?	Yes. Standard Dental Plan: $100 for basic services, $100 for major services. Premier Dental Plan: $75 for basic and major services combined. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network: $3,000 per person/$6,000 per family; Out-of-Network: $6,000 per person/$12,000 per family.	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.
What is not included in the out–of–pocket limit?	Premiums, balance billing, health care this plan does not cover, prescription drugs, vision, dental, deductibles and penalties for failure to obtain pre-authorization.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.

Questions: Call 1-800-638-2972 or visit us at www.anthem.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.anthem.com or call 1-866-814-3796.	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, co-payments** and **co-insurance** 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-pay	50% co-insurance	-- None --
	Specialist visit	$25 co-pay	50% co-insurance	-- None --
	Other practitioner office visit	30% co-insurance for chiropractic	50% co-insurance for chiropractic	Chiropractic limited to 12 visits per year per person, combined in and out of network
	Preventive care/screening/immunization	No charge	Not covered	-- None --

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	Physician's office: No charge; Other settings: 30% co-insurance	50% co-insurance	-- None --
	Imaging (CT/PET scans, MRIs)	30% co-insurance	50% co-insurance	-- None --
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kroger.com.	Generic drugs	Retail: 10% co-insurance ($7.50 minimum, $75 maximum); Mail order: 10% co-insurance or $15 to maximum of $75	Not covered	Covers up to a 34-day supply (retail); 102-day supply (mail order). Retail prescriptions generaly must be obtained from Kroger-owned pharmacy. If you elect a brand name drug when a generic is available, you must pay the generic co-pay plus the difference in cost between the generic and brand name drug.
	Formulary brand	Retail: 20% co-insurance ($25 minimum, $100 maximum); Mail order: 20% co-insurance or $30 to maximum of $100	Not covered	
	Non-formulary brand	Retail: 50% co-insurance ($40 minimum, $150 maximum); Mail order: 50% co-insurance or $60 to maximum of $150	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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 co-pay, then 30% co-insurance	$400 co-pay, then 50% co-insurance	-- None --
	Physician/surgeon fees	30% co-insurance	50% co-insurance	-- None --
If you need immediate medical attention	Emergency room services	$100 co-pay, then 30% co-insurance, waived if admitted	$100 co-pay, then 30% co-insurance	-- None --
	Emergency medical transportation	No charge	50% co-insurance	Pre-authorization required for air ambulance services
	Urgent care	$25 co-pay, then 20% co-insurance	$50 co-pay, then 50% co-insurance	-- None --
If you have a hospital stay	Facility fee (e.g., hospital room)	$25 co-pay, then 30% co-insurance	$300 co-pay, then 50% co-insurance	Pre-authorization required
	Physician/surgeon fee	30% co-insurance	50% co-insurance	-- None --
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Outpatient facility: 30% co-insurance; Outpatient office visit: $25 co-pay	50% co-insurance	-- None --
	Mental/Behavioral health inpatient services	$25 co-pay, then 30% co-insurance	$300 co-pay, then 50% co-insurance	Pre-authorization required
	Substance use disorder outpatient services	Outpatient facility: 30% co-insurance; Outpatient office visit: $25 co-pay	50% co-insurance	-- None --
	Substance use disorder inpatient services	$25 co-pay, then 30% co-insurance	$300 co-pay, then 50% co-insurance	Pre-authorization required

Common Medical Event	Service You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$20 co-pay	50% co-insurance	-- None --
	Delivery and all inpatient services	$25 co-pay, then 30% co-insurance	$300 co-pay, then 50% co-insurance	-- None --
If you need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	Limited to 30 visits per calendar year; pre-authorization required
	Rehabilitation services	Speech therapy: 30% co-insurance; physical/ occupational therapy: 20% co-insurance visits 1-40, 30% co-insurance visits 41-60.	50% co-insurance	Physical and occupational therapy limited to 60 visits per year; speech therapy limited to 20 visits per year. Pre-authorization required for inpatient services.
	Habilitation services	Not covered	Not covered	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	30% co-insurance	50% co-insurance	Pre-authorization required for inpatient services
	Durable medical equipment	30% co-insurance	50% co-insurance	Pre-authorization required for some equipment
	Hospice service	30% co-insurance	30% co-insurance	Pre-authorization required
If your child needs dental or eye care	Eye exam	$10 co-pay	No charge up to $46 then 100%	Limited to once every 12 months
	Glasses	No charge for lenses; no charge for frames up to $120 retail value then 80% co-insurance.	No charge up to $40 for single vision lenses and up to $45 for frames, then 100%	Lenses limited to once every 12 months; frames limited to once every 24 months
	Dental check-up	Standard Plan: 10% co-insurance; Premier Plan: No charge	Standard Plan: 10% co-insurance; Premier Plan: No charge	Limited to $2,000 annual maximum

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	• Habilitation services	• Routine foot care
• Bariatric surgery	• Hearing aids	• Weight loss programs

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.)		
• Chiropractic care	• Infertility treatment (covers diagnosis but not treatment)	• Private-duty nursing (Covered only when provided by home health care agency; pre-authorization required for services in the home)
• Cosmetic surgery (pre-authorization required for certain services)	• Long-term care	• Routine eye care (Adult)
• Dental care (Adult) (up to $2,000 annual maximum)	• Non-emergency care when traveling outside the U.S.	

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 the plan at 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.

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:** $7,540
- **Plan pays** $4,830
- **Patient pays** $2,710

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	$500
Co-pays	$30
Co-insurance	$2,030
Limits or exclusions	$150
Total	**$2,710**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,960
- **Patient pays** $1,440

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	$500
Co-pays	$220
Co-insurance	$640
Limits or exclusions	$80
Total	**$1,440**

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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