Bakers/FELRA Health & Welfare Fund: Plan 1

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

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 (866) 662-2537.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Major Medical: $300 person/ $600 family. Doesn't apply to prescription drugs, dental, vision, some preventive care, and "Basic Benefits" as described by the Plan. Balance billing, co-insurance amounts, co-pays, 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. Dental: $50 person/$150 family. 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?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no out-of-pocket limit.	Not applicable because there's no out-of-pocket limit on your expenses.
Is there an overall annual limit on what the plan pays?	Yes. $2 million.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see www.cignasharedadministration.com, call (800) 342-3289.	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 In-Network Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	You pay 20% co-insurance for first 2 visits/year, after ded.	No coverage provided.	After the first 2 visits/year the Plan pays $10/visit, up to $600/year. You pay 20% co-insurance.
	Specialist visit	You pay 20% co-insurance for first 2 visits/year after ded.	No coverage provided.	
	Other practitioner office visit	You pay a $5 co-pay for a chiropractor visit.	No coverage provided.	Max chiropractor payment is $40/visit, with a $500/person, $1,000/family annual max.
	Preventive care/screening/immunization	What you pay varies based on the type of care and your age.	No coverage provided.	Some preventive services provided under Basic Benefits, some under Major Medical. No cost for well-child visits (max 8 visits) & vaccines up to age 6, no coverage age 6 and older.

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)	You pay $0 for diagnostic allowed charges up to first $100 per quarter.	No coverage provided.	You pay 20% co-insurance on the balance of charges in excess of $100/quarter, after the deductible.
	Imaging (CT/PET scans, MRIs)	You pay $0 for imaging allowed charges up to the first $100/quarter.	No coverage provided.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mycatamaranrx.com.	Generic drugs	$10 co-pay retail, $20 co-pay mail order.	No coverage provided.	Limited to 30-day supply retail/90-day supply mail order. If you request a brand name drug when a generic is available you must also pay the difference in cost. Some prescriptions require pre-authorization or participation in a step-therapy program.
	Preferred brand drugs	$15 co-pay retail, $30 co-pay mail order.	No coverage provided.	
	Non-preferred brand drugs	$30 co-pay retail, $60 co-pay mail order.	No coverage provided.	
	Specialty drugs	Same as above but only provided through BioScript.	No coverage provided.	You must contact BriovaRx at (855) 427-4682 for specialty pharmacy drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery	You pay $0 up to the CIGNA allowed amount.	No coverage provided.	Balances over the Cigna maximum are not covered.
	Physician/surgeon fees	No charge up to allowed amounts, 20% co-insurance thereafter.	No coverage provided.	Limited to 1 visit/day same phys. or surgeon, no coverage for pre/post-op care from provider performing procedure.
If you need immediate medical attention	Emergency room services	$25 facility fee co-pay; 20% co-ins. on physician fees after deductible and Plan's $10 payment.	No coverage provided.	Out-of-network covered the same as in-network if determined to be true emergency.
	Emergency medical transportation	You pay $0 provided charges deemed reasonable by the Fund Administrator.	No coverage provided.	No coverage for ambulance transport between facilities in non-emergency situations. Out-of-network covered the same as in-network if determined to be true emergency.
	Urgent care	You pay 20% co-ins. after deductible.	No coverage provided.	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 hospital stay	Facility fee (e.g., hospital room)	You pay $0 up to 70 days in a semi-private room, then 20% co-insurance after the deductible.	No coverage provided.	Pre-cert before admission, or 48 hrs. after in an emergency, or the Plan's payment is reduced 20% to a max reduction of $1,000.
	Physician/surgeon fee	You pay $0 up to $800 per procedure, then 20% co-insurance, after deductible.	No coverage provided.	Limited to 1 visit/day same phys. or surgeon, no coverage for pre/post-op care same provider who performed procedure.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	You pay 20% co-insurance, after deductible, for the first two visits/year.	No coverage provided.	After the first 2 visits/year the Plan pays $10/visit, up to $600/year. You pay 20% co-insurance.
	Mental/Behavioral health inpatient services	You pay $0 up to 70 days in a semi-private room, then 20% co-insurance after the deductible.	No coverage provided.	Pre-cert before admission, or 24 hrs. after in an emergency, or the Plan's payment is reduced 20% to a max reduction of $1,000.
	Substance use disorder outpatient services	You pay 20% co-insurance, after deductible, for the first two visits/year.	No coverage provided.	After the first 2 visits/year the Plan pays $10/visit, up to $600/year. You pay 20% co-insurance.
	Substance use disorder inpatient services	You pay $0 up to 70 days in a semi-private room, then 20% co-insurance after the deductible.	No coverage provided.	Pre-cert before admission, or 24 hrs. after in an emergency, or the Plan's payment is reduced 20% to a max reduction of $1,000.
If you are pregnant	Prenatal and postnatal care	You pay 20% co-insurance for first 2 visits/year, after ded.	No coverage provided.	After the first 2 visits/year (combined with all primary care/specialist visits) the Plan pays $10/visit, up to $600/year. You pay 20% co-insurance.
	Delivery and all inpatient services	You pay $0 for a semi-private room, $0 up to an $800 max per procedure, then 20% coinsurance, after deductible.	No coverage provided.	Charges for the infant are payable under the baby's own coverage as a dependent.

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 need help recovering or have other special health needs	Home health care	You pay $0 when provided in lieu of hospitalization, for up to 70 days.	No coverage provided.	You pay 20% co-insurance on the balance of charges. Pre-cert before admission or payment is reduced 20% to a max reduction of $1,000.
	Rehabilitation services	Outpatient: 20% co-insurance after the deductible.	No coverage provided.	Inpatient rehab covered the same as an inpatient hospital stay - see page 4.
	Habilitation services	No coverage provided.	No coverage provided.	You must pay 100% of these expenses, even in-network.
	Skilled nursing care	Outpatient: you pay 20% co-insurance after the deductible. Inpatient: no charge up to 70 days, then 20% consurance after deductible.	No coverage provided.	Inpatient: must go directly to first available facility. No coverage if more than 30 days pass between hospital discharge and admission.
	Durable medical equipment	You pay 20% co-insurance after the deductible.	No coverage provided.	Fund reserves the right to purchase rather than rent some equipment to control costs.
	Hospice service	You pay nothing for hospice care up to 70 days.	No coverage provided.	Pre-cert before admission or payment is reduced 20% to a max reduction of $1,000. 70 day max/year.
If your child needs dental or eye care	Eye exam	No charge.	You pay up front and seek to be reimbursed.	Limited to 1 exam/24 months; out-of-network up to $46/exam maximum reimbursement.
	Glasses	No charge.		Limited to 1 pair/24 months; dollar maximum applies to out-of-network frames & lenses.
	Dental check-up	You pay nothing after $50 deductible.	You pay any balance billing at the time of service.	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
- Bariatric surgery
- Cosmetic surgery (Except after non-occupational injury or mastectomy.)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- 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 (Up to Plan maximums.)
- Dental care (Adult) (Up to Plan maximums.)
- Hearing aids (Only when needed from an injury.)
- Private-duty nursing (Out-patient only.)
- Routine eye care (Adult) (Up to Plan maximums.)

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 (866) 662-2537. 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 Administrative Manager at the principal office of the Fund: 911 Ridgeback Road, Sparks, Maryland 21152. Or you may contact the Department of Labor's Employee Benefits Security Administration at (688) 444-EBSA (3273) or **www.dol.gov/ebsa/healthreform**.

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** $5,640
- **Patient pays** $1,900

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	$60
Co-insurance	$1,390
Limits or exclusions	$150
Total	**$1,900**

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

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

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	$440
Co-insurance	$300
Limits or exclusions	$300
Total	**$1,340**

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.

Questions: Call (866) 662-2537 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 (866) 662-2537 to request a copy.