# UFCW Local 1500 Welfare Fund: Part-Time ACA Plan

**Coverage for: Individual + Spouse* | Plan Type: EPO**

***This Plan covers Employees only. Spouses are covered for Dental and Vision benefits only.**

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, 1-800-522-0456. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.associated-admin.com or call 1-800-522-0456 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $5,600/per calendar year. | The Fund pays the 1st $400 @ 100% of the Anthem allowance for all eligible expenses, then **deductible** is applied. Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. **Preventive** care and the 1st $400 @ 100% of the Anthem allowance for all eligible expenses | For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No | You don't have to meet **deductibles** for specific services. |
| **What is the out-of-pocket limit for this plan?** | For Medical Benefits $5,600, for Prescription Drug Benefits $1,000 | The **out-of-pocket limit** is the most you could pay in a year for covered services. |
| **What is not included in the out-of-pocket limit?** | **Copayments** on certain services, **premiums**, **balance-billing** charges, and health care this **plan** doesn't cover | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Will you pay less if you use a network provider?** | Yes. See www.anthem.com or call 1-800-810-BLUE for a list of **network providers** | This plan uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**. Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services. |
| **Do you need a referral to see a specialist?** | No | You can see the **specialist** you choose without a **referral**. |

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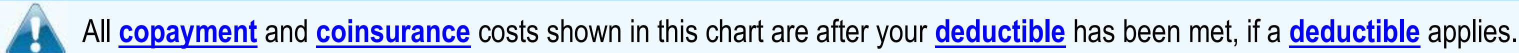

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | No charge | Not Covered | None |
| | Specialist visit | No charge | Not Covered | None |
| | Preventive care/screening/ immunization | No charge. **Deductible** does not apply | Not Covered | None |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | No Charge | Not Covered | **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500 |
| **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 | Retail: $20 Mail: $40 | Not Covered | Retail limited to 34-day supply; mail order limited to 90 day supply. If you can obtain a brand name medication when a generic equivalent is available, you pay the generic **coinsurance** plus the difference between the cost of the brand name drug and the generic. Utilization Management Program in effect. **Preauthorization** required for some drugs. Failure to do so may result in a denial of benefits. For more information contact Express Scripts at 1-877-861-8145 |
| | Preferred brand drugs | Retail: $30 Mail: $60 | Not Covered | |
| | Non-preferred brand drugs | Retail: $60 Mail: $120 | Not Covered | |
| | Specialty drugs | Same as non-preferred | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | Not Covered | **Preauthorization** required for certain services. Failure may result in a denial or penalty of 50% up to $500 |
| | Physician/surgeon fees | No Charge | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | $100 **copayment** | $100 **copayment** and balance between charge and **In-network rate** | **Copayment** waived if admitted. Limited to initial visit for **Emergency Medical Conditions** as defined by the Summary Plan Description |
| | Emergency medical transportation | No Charge | Balance between charge **and In-network rate** | If air ambulance, condition must warrant air ambulance services |
| | Urgent care | No Charge | Not Covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | Not Covered – except in emergencies. Balance between charge **and In-network rate** | **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500. Semi-private room and board allowed only |
| | Physician/surgeon fees | No Charge | Not Covered | **Preauthorization** required for certain services. Failure may result in a denial or penalty of 50% up |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
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| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | to $500 |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No Charge | Not Covered | None |
| | Inpatient services | No Charge | Not Covered | **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500. Semi-private room and board allowed only |
| **If you are pregnant** | Office visits | No Charge | Not Covered | Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound) |
| | Childbirth/delivery professional services | No Charge | Not Covered | |
| | Childbirth/delivery facility services | No Charge | Not Covered | **Preauthorization** should be obtained within first 3 months of pregnancy, but not required |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | Not Covered | 200 visits/year. 40 visits/year without prior hospitalization not to exceed 200 visit/year combined maximum. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500 |
| | Rehabilitation services | No Charge | Not Covered | 30 visits/year for each service. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500 |
| | Habilitation services | No Charge | Not Covered | |
| | Skilled nursing care | No Charge | Not Covered | 60 days/year. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500 |
| | Durable medical equipment | No Charge | Not Covered | **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500 |
| | Hospice services | No Charge | Not Covered | 210 days/lifetime. **Preauthorization** required. Failure may result in a denial or penalty of 50% up to $500 |
| **If your child needs dental or eye care** | Children's eye exam | Not covered for children | Not covered for children | |
| | Children's glasses | Not covered for children | Not covered for children | |
| | Children's dental check-up | Not covered for children | Not covered for children | |

## Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|---|
| • Cosmetic Surgery<br>• Hearing Aids | • Infertility Treatment<br>• Long-term care<br>• No coverage for spouse, except Dental and Vision benefits | • Routine foot care<br>• Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|---|---|
| • Acupuncture<br>• Bariatric Surgery | • Chiropractic care<br>• Dental care (Adult) | • Non-emergency care when traveling outside the U.S.<br>• Private-duty nursing<br>• Routine eye care (Adult) |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform . Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the **plan** at 1-800-522-0456. 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.

**Does this plan provide Minimum Essential Coverage? Yes.**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-522-0456 Ext. 1336

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

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$5,600**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,600 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $200 |
| **The total Peg would pay is** | **$5,900** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$5,600**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,900 |
| Copayments | $1,000 |
| Coinsurance | |
| *What isn't covered* | |
| Limits or exclusions | $200 |
| **The total Joe would pay is** | **$3,100** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$5,600**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **0%**

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,500** |

The plan would be responsible for the other costs of these EXAMPLE covered services.