Northern Minnesota-Wisconsin Area Retail Food Health and Welfare Fund: Class A

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage Period: 01/01/2016 - 12/31/2016**

Coverage for: Single and Family (Active Employee & Dependents) | **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 by calling 1-800-570-1012.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person/**$1,000** family in-network and out-of-network. Unless otherwise specified, the following do not count toward deductible: emergency room deductible; physician office visits; mental health professional office visits; well child care; immunizations; and certain routine screenings.	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 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** emergency room **deductible** per sickness visit. **$50** person/**$100** family for Preferred Provider Pharmacy Prescription Drug Benefits. 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. Medical: **$4,600** person/ **$9,200** family in-network and out-of-network. PPRx: **$2,000** single/ **$4,000** 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.

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Important Questions	Answers	Why this Matters:
What is not included in the medical out–of–pocket limit?	Premiums; balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See: www.bluecrossmn.com for a list of in-network 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 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	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 8. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions[1]
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness, including mental/behavioral health	$35 copay/visit	$35 copay/visit	None
	On-Line Care Anywhere and Retail Clinic visits	$10 copay/visit	$10 copay/visit	None
	Specialist visit	$35 copay/visit	$35 copay/visit	None
	Other practitioner office visit	20% coinsurance for chiropractor	20% coinsurance for chiropractor	Chiropractor visits limited to 16/year.
	Preventive care/screening/immunization	No charge	$35 copay/visit for routine exams; well child care no deductible, $35 copay, then 20% coinsurance; routine immunizations no charge; diagnostic x-ray and lab subject to deductible, 20% coinsurance	In-network benefit allowed only for services mandated under the PPACA and described preventive health services by the federal government. If the Plan does not have an in-network provider who can provide a particular covered preventive service, then it will cover the item or service without cost-sharing when performed by an out-of-network provider acting within the scope of his/her license or certification.

[1] Only the major limitations and exclusions are listed; there may be others. Expenses that are not Medically Necessary are not covered. Maximum limits on the dollar value of benefits do not apply to any item or service that is an Essential Health Benefit. See the SPD or call the Plan Administrator at 1-800-570-1012 for more information.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions[1]
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.envisionrx.com or by calling 1-800-361-4542.	Generic drugs	10% coinsurance, with a minimum copay of $15 per prescription (retail and mail service)	Not covered	In-network retail: Covers up to a 90-day supply of generic drugs and up to a 30-day supply for brand name drugs; In-network mail: 90-day supply for both generic and brand name drugs.
	Preferred brand name drugs	Retail: 20% coinsurance to a maximum copay of $75 per prescription. Mail: 20% coinsurance, with a minimum/maximum copay of $25/$150 per prescription.	Not covered	

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions[1]
If you need drugs to treat your illness or condition (continued) More information about **prescription drug coverage** is available at www.envisionrx.com or by calling 1-800-361-4542.	Non-Preferred brand name drugs	Retail: 20% coinsurance, with a minimum/maximum copay of $35/$150 per prescription. Mail: 20% coinsurance, with a minimum/maximum copay of $70/$300 per prescription.	Not covered	In-network retail: Covers up to a 90-day supply of generic drugs and up to a 30-day supply for brand name drugs; In-network mail: 90-day supply for both generic and brand name drugs.
	OTC aspirin, smoking cessation products including OTC nicotine replacement therapy and federal legend drugs, federal legend fluoride, OTC iron supplements, and OTC folic acid upon a physician's written prescription and generic contraceptive products for women available by prescription only	No charge for generic and single source brand name drugs (retail and mail)	Not covered	PPRx deductible does not apply.
	Specialty Pharmacy Preferred generic and brand Non-Preferred generic and brand	20% coinsurance, with a maximum copay of $100 20% coinsurance, with a maximum copay of $350	Not covered	In-network Specialty Pharmacy: Covers a 30-day supply.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions[1]
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room services for the treatment of a sickness.	$100 deductible	$100 deductible	Waived if admitted within 24 hours of the visit. Not applicable for injuries.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$35 copay/visit	$35 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Limited to hospital's semi-private room rate (or private room rate when medically necessary)
	Physician/surgeon fee	20% coinsurance	20% coinsurance of Reasonable and Customary charge for surgeon and 20% of surgical allowance for assistant surgeon	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copay/office visit; 20% coinsurance for outpatient services	$35 copay/office visit; 20% coinsurance for outpatient services	None
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	None
	Substance use disorder outpatient services	$35 copay/office visit; 20% coinsurance for outpatient services	$35 copay/office visit; 20% coinsurance for outpatient services	None
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	None

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions[1]
If you are pregnant	Prenatal and postnatal care	20% coinsurance	20% coinsurance	None
	Delivery and all inpatient services	20% coinsurance	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	$35 copay/visit	$35 copay/visit	None
	Rehabilitation services	20% coinsurance	20% coinsurance	Physical and occupational therapy limited to combined maximum of 15 visits/disability (plus 11 additional visits if prior authorized). Speech therapy limited to 15 visits/disability. For disabilities caused by stroke: 25 visits/disability combined for physical and occupational therapy and 25 visits/disability for speech therapy.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	20% coinsurance	20% coinsurance	Limited to 30 days following one period of hospital confinement.
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice service	20% coinsurance	20% coinsurance	None
If your child needs dental or eye care	Eye exam	20% coinsurance	20% coinsurance	Limited to 1 exam per calendar year. No deductible.
	Glasses	50% coinsurance	50% coinsurance	Limited to 1 set of lenses and frames every calendar year. No deductible.
	Dental check-up	10% coinsurance of Reasonable and Customary charge	10% coinsurance of Reasonable and Customary charge	Limited to 1 check-up/6 months.

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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
- Cosmetic surgery, except for repair of damage due to injury within one year after the date of the accident
- Habilitation services
- Hearing aids
- Long-term care
- Private-duty nursing
- 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 these services.)

- Bariatric surgery, when medically necessary and prior authorized
- Chiropractic care, up to 16 visits/year
- Dental care (Adult and Children)
- Infertility treatment, up to $200/year
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Children)

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 1-800-570-1012. 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: 1-800-570-1012. You also may contact the Department of Labor's Employee Benefits Security Administration at: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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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.**

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. .

The costs for having a baby were calculated on the basis of individual coverage for the mother without dependent coverage.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,220
- **Patient pays** $2,320

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	$250
Copays (drugs)	$15
Coinsurance	$1,000
Limits or exclusions	$1,055
Total	**$2,320**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,000
- **Patient pays** $1,400

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	$250
Copays	$500
Coinsurance	$600
Limits or exclusions	$50
Total	**$1,400**

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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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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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