Board of Trustees of the Rocky Mountain UFCW Unions & Employers Health Benefit Plan: Plan C CCN

Coverage Period: 01/01/2017 - 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual, 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 by calling the plan at 800-527-1647 or Cigna at 1-800-Cigna24.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$700**/person, **$2,100**/family; doesn't apply to in-network preventive care, in-network office visits, prescription drugs. Copays don't 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?	No.	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.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: coinsurance limit: **$4,000**/person, **$7,000**/family; out-of-pocket limit: **$6,350**/person, **$12,700**/family. Out-of-network: coinsurance limit: **$12,000**/person, **no family maximum**; **no out-of-pocket limit**.	The **out-of-pocket limit** includes the medical deductible, copayments and coinsurance and 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?	Coinsurance limit: Premium, balance-billed charges, copays, plan deductibles, prescription drugs, dental and vision expenses, preauthorization penalties, and health care this plan doesn't cover. Out-of-pocket limit: Premium, balance-billed charges, dental and vision expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.

Questions: Call the plan at 800-527-1647 or Cigna at 1-800-Cigna24, visit us at www.myCigna.com or refer to your summary plan description. If you aren't clear about any of the underlined terms used in this form, see see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-800-Cigna24 to request a copy.

No benefit or benefit period in this summary is guaranteed and the Board of Trustees reserves the right to interpret, amend, or modify this summary. If there are any inconsistencies between this summary and the Plan's Rules and Regulations, the latter document will control.

Important Questions	Answers	Why this Matters:
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.
Does this plan use a network of providers?	Yes . For a list of participating **providers**, see www.myCigna.com or call 1-800-Cigna24. For mental health benefits, call Mines & Associates at 800-873-7138.	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 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 5. 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.

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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit; 35% coinsurance/procedures during office visit	50% coinsurance	Deductible doesn't apply to in-network office visits.

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
	Specialist visit	CCN Specialist: $50 copay/ visit; Non-CCN Specialist: $60 copay/visit; 35% coinsurance/procedures during office visit.	50% coinsurance	
	Other practitioner office visit	35% coinsurance for Chiropractor	50% coinsurance for Chiropractor	Coverage for Chiropractic services is limited to 15 days/year.
	Preventive care/screening/immunization	No charge	50% coinsurance	Deductible doesn't apply to in-network services; out-of-network limited to mammograms, pap smears, PSA testing, colonoscopies and immunizations for children under age 3 only
If you have a test	Diagnostic test (x-ray, blood work)	35% coinsurance	50% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	$75 copay/scan per day, plus 35% coinsurance	$75 copay/scan per day, plus 50% coinsurance	Preauthorization required; $100 benefit reduction if fail to preauthorize.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myCigna.com.	Generic drugs	Retail: $5 copay; Maintenance Medication: $10 copay	Not Covered	If you receive a brand name drug when a generic drug is available, you will pay the generic drug copay plus the difference in cost between the generic and brand name drug. Some exceptions apply. Deductible doesn't apply; coverage is limited up to a 34-day supply (retail and specialty drugs) and 90-day supply for maintenance medication; certain drugs may be subject to prior authorization or step therapy prior authorization is required for specialty drugs.
	Preferred brand drugs	Retail: 20% coinsurance up to $50/drug; Maintenance Medication: 20% coinsurance up to $100/drug.	Not Covered	
	Non-preferred brand drugs	Retail: 30% coinsurance up to $75/drug; Maintenance Medication: 30% coinsurance up to $150/drug.	Not Covered	
	Specialty drugs	20% coinsurance up to $100/drug	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% coinsurance	50% coinsurance	---None---

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
	Physician/surgeon fees	35% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	35% coinsurance	35% coinsurance	---None---
	Emergency medical transportation	35% coinsurance	35% coinsurance	
	Urgent care	35% coinsurance	35% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance	50% coinsurance	Preauthorization required; $100 benefit reduction if fail to preauthorize
	Physician/surgeon fee	35% coinsurance	50% coinsurance	---None---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office visit: $40 copay/visit; Facility and procedures during office visit: 35% coinsurance	50% coinsurance	Deductible doesn't apply to in-network office visits.
	Mental/Behavioral health inpatient services	35% coinsurance	50% coinsurance	Preauthorization required; $100 benefit reduction if fail to preauthorize
	Substance use disorder outpatient services	Office visit: $40 copay/visit; Facility and procedures during office visit: 35% coinsurance	50% coinsurance	Deductible doesn't apply to in-network office visits.
	Substance use disorder inpatient services	35% coinsurance	50% coinsurance	Preauthorization required; $100 benefit reduction if fail to preauthorize
If you are pregnant	Prenatal and postnatal care	Applicable office visit copay; 35% coinsurance for facilities and any procedures during office visit	50% coinsurance	Certain prenatal services may be covered under the preventive care benefit outlined on page 3.
	Delivery and all inpatient services	35% coinsurance	50% coinsurance	---None---
If you need help recovering or have other special health	Home health care	35% coinsurance	35% coinsurance	Coverage is limited to 40 days/year; preauthorization required; $100 benefit reduction if fail to preauthorize

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
needs	Rehabilitation services	35% coinsurance; 50% coinsurance/ Speech Pathologist (non Hospital)	50% coinsurance; 50% coinsurance/ Speech Pathologist (non Hospital)	Speech Pathologist limited to 50 days/year.
	Habilitation services	Not Covered	Not Covered	Coverage is excluded
	Skilled nursing care	35% coinsurance	50% coinsurance	---None---
	Durable medical equipment	35% coinsurance	50% coinsurance	Preauthorization required; $100 benefit reduction if fail to preauthorize
	Hospice service	35% coinsurance	35% coinsurance	---None---
If your child needs dental or eye care	Eye exam	No charge	No charge	---None---
	Glasses	All charges in excess of two-calendar year limit	All charges in excess of two-calendar year limit	Coverage limited to following two calendar year limits: $240 (single), $260 (bifocal), $290 (trifocal) for frames & lenses
	Dental check-up	No charge	20% coinsurance	Coverage limited to 2 visits/12 month period

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 to repair damage from an accident, that is incidental to or follows surgery that results from trauma or infection, to enable you to eat, or as required by law
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing,
- 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 (specific criteria must be met)
- Chiropractic care
- Dental care (Adult), $1,000/year - Preventive Only
- Routine eye care (Adult), up to two-calendar year limit
- Routine foot care

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 800-527-1647 or Cigna at 1-800-Cigna24. 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 800-527-1647, Cigna at 1-800-Cigna24, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform.

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:

Para obtener asistencia en Español, llame al 1-800-244-6224.

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.

- **Amount owed to providers:** $7,540
- **Plan pays** $4,460
- **Patient pays** $3,080

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	$700
Co-pays	$70
Co-insurance	$2,280
Limits or exclusions	$30
Total	**$3,080**

This example assumes the hospital charges for the baby are bundled with the mother's charges. If billed separately, a separate deductible would apply if you have family coverage.

- **Amount owed to providers:** $5,400
- **Plan pays** $4,270
- **Patient pays** $1,130

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	$140
Co-pays	$670
Co-insurance	$0
Limits or exclusions	$320
Total	**$1,130**

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.
- Sample care costs calculated assuming individual only coverage only.

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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