

Warehouse Local 730 Health Fund: Plan E/Active

Coverage Period: 01/01/2021 – 12/31/2021

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

Coverage for: Individual + Family | Plan Type: PPO



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, call 1-800-730-2241. 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 1-800-730-2241 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$800 person/ \$1,600 family. Balance billing, excluded services, Preventive care , deductibles for specific services do not count toward the deductible .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there services covered before you meet your deductible ?	Yes. Preventive care and COVID-19 Testing	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. 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.go/coverage/preventive-care-benefits/ . This plan also covers COVID-19 testing without any cost-sharing.
Are there other deductibles for specific services?	Yes. \$100 deductible per hospital confinement. 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. You don't have to meet deductibles for specific services. See chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	Yes. Medical in- network : \$6,250 Individual / \$12,500 Family Prescription Drugs: \$1,100 Individual/ \$2,200 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges , health care this plan does not cover, and penalties for failure to obtain pre-authorization for services.	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.cignasharedadministration.com or call 1-800-768-4695 for a list of	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 , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance

	<u>network providers</u>	billing). 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 .

 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	After Plan pays \$35/visit, you pay 20% coinsurance (UCR)	After Plan pays \$35/visit, you pay 20% coinsurance (UCR)	Maximum of 90 visits/year except for preventive services
	Specialist visit	After Plan pays \$35/visit, you pay 20% coinsurance (UCR)	After Plan pays \$35/visit, you pay 20% coinsurance (UCR)	Maximum of 90 visits/year except for preventive services
	Preventive care/screening/immunization	No charge	No charge	No deductible for in-network/ out-of-network visits
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance (UCR)	20% coinsurance (UCR)	Preauthorization required for outpatient services
	Imaging (CT/PET scans, MRIs)	20% coinsurance (UCR)	20% coinsurance (UCR)	Preauthorization required for outpatient services
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mycigna.com	Generic drugs	\$15.00 copay per prescription	\$15.00 copay per prescription	Preauthorization required for prescriptions of more than a 34-day supply or 180 tablets. You are responsible for a copay and difference in cost if you elect a name brand drug when a generic option is available. Not covered if Wal-Mart or Sam's Club pharmacies are used.
	Preferred brand drugs	\$40.00 copay per prescription	\$40.00 copay per prescription	
	Non-preferred brand drugs	\$75.00 copay per prescription	\$75.00 copay per prescription	
	Specialty drugs	\$75.00 copay per prescription	\$75.00 copay per prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance (UCR)	20% coinsurance (UCR)	Preauthorization required for outpatient services
	Physician/surgeon fees	20% coinsurance (UCR)	20% coinsurance (UCR)	Preauthorization required for outpatient services
If you need immediate medical attention	Emergency room care	20% coinsurance (UCR)	20% coinsurance (UCR)	Expenses must be incurred within 72 hours of accident or illness. Non-emergency illness not covered
	Emergency medical	20% coinsurance	20% coinsurance (UCR)	-----None-----

For more information about limitations and exceptions, see the plan or policy document at [www.associated-admin.com](#)

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)	
	transportation	(UCR)		
	Urgent care	After Plan pays \$35/visit, you pay 20% <u>coinsurance</u> (UCR)	After Plan pays \$35/visit, you pay 20% <u>coinsurance</u> (UCR)	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> (UCR)	20% <u>coinsurance</u> (UCR)	<u>Preauthorization</u> for all admissions or benefits required. \$100 deductible per confinement. Max/ 180 days inpatient medical, surgical, mental health, substance abuse disorder
	Physician/surgeon fees	20% <u>coinsurance</u> (UCR)	20% <u>coinsurance</u> (UCR)	Maximum of 90 visits/year
If you need mental health, behavioral health, or substance abuse services	Outpatient services	After Plan pays \$35/visit, you pay 20% <u>coinsurance</u> (UCR)	After Plan pays \$35/ visit, you pay 20% <u>coinsurance</u> (UCR)	Maximum of 90 visits/year
	Inpatient services	20% <u>coinsurance</u> (UCR)	20% <u>coinsurance</u> (UCR)	<u>Preauthorization</u> for all admissions or benefits required. \$100 deductible per confinement. Max/ 180 days inpatient medical, surgical, mental health, substance abuse disorder
If you are pregnant	Office visits	Prenatal - No charge/ Postnatal - After Plan pays \$35/visit, you pay 20% <u>coinsurance</u> (UCR)	Prenatal - No charge/ Postnatal - After Plan pays \$35/visit, you pay 20% <u>coinsurance</u> (UCR)	<u>Preventive</u> prenatal care at no charge.
	Childbirth/delivery professional services	20% <u>coinsurance</u> (UCR)	20% <u>coinsurance</u> (UCR)	<u>Preauthorization</u> required for hospital admissions. \$100 deductible per hospital confinement
	Childbirth/delivery facility services	20% <u>coinsurance</u> (UCR)	20% <u>coinsurance</u> (UCR)	<u>Preauthorization</u> required for hospital admissions. \$100 deductible per hospital confinement
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u> (UCR)	20% <u>coinsurance</u> (UCR)	<u>Preauthorization</u> required
	Rehabilitation services	Outpatient - 20% <u>coinsurance</u> (UCR)	Outpatient - 20% <u>coinsurance</u> (UCR)	<u>Preauthorization</u> required
	Habilitation services	Outpatient - 20% <u>coinsurance</u> (UCR)	Outpatient - 20% <u>coinsurance</u> (UCR)	<u>Preauthorization</u> required
	Skilled nursing care	Outpatient - 20%	Outpatient - 20%	<u>Preauthorization</u> required

For more information about limitations and exceptions, see the plan or policy document at www.associated-admin.com

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)	
		coinsurance (UCR)	coinsurance (UCR)	
	Durable medical equipment	20% coinsurance (UCR)	Not covered	Must use CareCentrix
	Hospice services	Inpatient - 20% coinsurance plus charges greater than \$3,000 /per period of care. Outpatient - 20% coinsurance plus charges greater than \$2,000 /per period of care	Inpatient - 20% coinsurance plus charges greater than \$3,000 /per period of care. Outpatient - 20% coinsurance plus charges greater than \$2,000 /per period of care	Patient with a life expectancy of six months or less. Certain lifetime limits may apply
If your child needs dental or eye care	Children's eye exam	\$10 copay /visit - in-network provider	Not covered	Once every 12 months – Group Vision Services
	Children's glasses	\$10 copay /visit - in-network provider	Not covered	Certain lenses once every 12 months, frames once every 24 months – Group Vision Services
	Children's dental check-up	No charge - participating provider	Not covered	Certain dental procedures are excluded. See benefits guide for details. Dental Health Centers

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](#).)

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery (generally excluded with certain exceptions) | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine foot care (Frequency limits apply) • Weight loss program |
|--|---|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | |
|---|---|
| <ul style="list-style-type: none"> • Bariatric surgery (If deemed medically necessary) • Chiropractic care (Ninth and subsequent visits must be pre-authorized) | <ul style="list-style-type: none"> • Dental care (Adult) • Hearing aids • 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 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.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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 1-800-730-2241.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-730-2241.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-730-2241.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-730-2241.

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	\$800
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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*	\$900
Copayments	\$10
Coinsurance	\$700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,670

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$800
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$5,600
--------------------	---------

In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$800
Copayments	\$1,000
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,920

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$800
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$2,800
--------------------	---------

In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$800
Copayments	\$10
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,110

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" above. The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.