

Meijer: Core Health Plan (CHP)

Coverage Period: 01/01/2014 – 12/31/2014

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

Coverage for: All Coverage Tiers | 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.resources.hewitt.com/meijer/ or by calling 1-866-681-6116.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In Network: \$1,750 Individual/ \$3,500 Family Out of Network: \$3,000 Individual/ \$6,000 Family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. \$150 Individual/ \$300 Family brand prescription drug deductible	
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In Network: \$5,000 Individual/ \$10,000 Family Out of Network: \$10,000 Individual/ \$20,000 Family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.bcbs.com or call 1-800-810-BLUE for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. Specialist needs to be a PPO participating provider.	You can see the <u>specialist</u> 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 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-866-681-6116 or visit us at www.resources.hewitt.com/meijer/.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary IMS H000131949 at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-866-681-6116 to request a copy.



- **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	\$30 copay/visit	50% coinsurance	—————none—————
	Specialist visit	\$60 copay/visit	50% coinsurance	Includes dermatology and podiatry
	Other practitioner office visit	30% coinsurance for chiropractor	50% coinsurance for chiropractor	Limited to 24 visits per plan year.
	Preventive care/screening/immunization	No charge	50% coinsurance	Well-woman exams, mammograms and child immunizations are included.
If you have a test	Diagnostic test (x-ray, blood work)	\$30 copay	50% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	—————none—————
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	\$4 copay/retail 30-day prescription; \$7 copay/retail 90-day prescription	Check with plan for details.	Retail pharmacy prescriptions only, no mail order. Note: Many diabetes supplies are formulary brand products and will not be covered under this plan.
	Formulary drugs	50% coinsurance after \$150 brand deductible; \$30 copay minimum	Check with plan for details.	—————none—————
	Nonformulary drugs	Not covered	Not covered	—————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
	Specialty drugs	Applicable formulary or nonformulary copays apply as stated above.	Check with plan for details.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	—————none—————
	Physician/surgeon fees	30% coinsurance	50% coinsurance	—————none—————
If you need immediate medical attention	Emergency room services	\$200 copay	\$200 copay	Copay waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	—————none—————
	Urgent care	\$60 copay	\$100 copay or 50% coinsurance, whichever is greater	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	—————none—————
	Physician/surgeon fees	30% coinsurance	50% coinsurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30 copay	50% coinsurance	—————none—————
	Mental/Behavioral health inpatient services	30% coinsurance	50% coinsurance	—————none—————
	Substance use disorder outpatient services	\$30 copay	50% coinsurance	—————none—————
	Substance use disorder inpatient services	30% coinsurance	50% coinsurance	—————none—————
If you are pregnant	Prenatal and postnatal care	Prenatal No charge; Postnatal \$30 copay	50% coinsurance	Dependent maternity services are not covered.

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
	Delivery and all inpatient services	30% coinsurance	50% coinsurance	Dependent maternity services are not covered.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 40 visits per year.
	Rehabilitation services	30% coinsurance	50% coinsurance	—————none—————
	Habilitation services	Not covered	Not covered	—————none—————
	Skilled nursing care	30% coinsurance	50% coinsurance	—————none—————
	Durable medical equipment	30% coinsurance	30% coinsurance	—————none—————
	Hospice service	30% coinsurance	50% coinsurance	—————none—————
If your child needs dental or eye care	Eye exam	Not covered	Not covered	—————none—————
	Glasses	Not covered	Not covered	—————none—————
	Dental check-up	Not covered	Not covered	—————none—————

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 <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Acupuncture (if prescribed for rehabilitation purposes) • Chiropractic care • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult) • 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

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 **1-866-681-6116**. 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: **1-800-452-6933** or visit us at www.bcbsm.com. Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-681-6116.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-681-6116.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-681-6116.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-681-6116.

—————*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 \$3,840
- Patient pays \$3,700

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	\$1,750
Copays	\$360
Coinsurance	\$1340
Limits or exclusions	\$150
Total	\$3,700

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

- Amount owed to providers: \$5,400
- Plan pays \$2,980
- Patient pays \$2,420

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	\$1,750
Copays	\$320
Coinsurance	\$270
Limits or exclusions	\$80
Total	\$2,420

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs assume Individual only coverage.
- 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.

Questions: Call 1-866-681-6116 or visit us at www.resources.hewitt.com/meijer/.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-866-681-6116 to request a copy.