

Food Depot

*Copay
Health Plan*

Health Insurance

2016

Food Depot Health Insurance 2016

Copay Plan

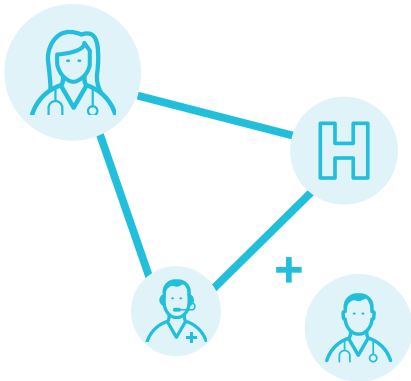
Great news!! We have been able to upgrade our benefits under the new UnitedHealthcare plan this year. Same deductible as last year, same HRA contribution but we have added a \$50 copay to see a specialist and copays for most all levels of prescriptions. We were able to lower dependent costs as well. Your payroll deductions will be taken out pre-tax. Once you are on the plan, you sign up for the entire year, no on and off. Through the Health reimbursement arrangement (HRA), Food Depot will contribute \$1,000 to the last part of the deductible, effectively making your deductible \$2,500. The \$1,000 is the total whether you elect employee coverage or dependent coverage.

	2016 Payroll Deduction
Employee Only	\$ 85
Employee and Spouse	\$375
Employee and Children	\$345
Family	\$595

For any questions throughout the year, please contact United Healthcare at **866-314-0335**

This booklet is a summary of benefits and actual plan documents will prevail in case of discrepancy.

Copay Plan



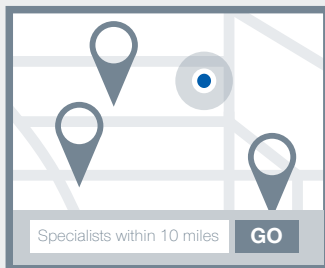
National Network and Out-of-Network Coverage

780,000+ doctors and health care professionals (clinics, labs, care centers, etc.)

5,700+ hospitals

30,000+ pharmacies

Look for care in our network first.



To help you save money, we make it easy for you to find network providers.

Search the **NETWORK** at welcometouhc.com/choiceplus.

*You won't need to worry about these costs for preventive care if you stay in the network. You may be required to receive approval for some services before they can be covered.

Get more protection with a national network and out-of-network coverage.

A network is a group of health care providers and facilities that have a contract with UnitedHealthcare. You can receive care and services from anyone in or out of our network, but you save money when you use the national network.

✓ There's coverage if you need to go out of the network.

Out-of-network means that a provider does not have a contract with us. Choose what's best for you. Just remember, out-of-network providers will likely charge you more.

✓ There's no need to choose a primary care provider (PCP) or get referrals to see a specialist.

Consider a PCP; they can be helpful in managing your care.

✓ Preventive care is covered 100% in our network.

DETAILED BENEFITS on pages 4-5.

Paying for network care

Co-payment (co-pay)*

You'll pay a fixed amount of money for each covered doctor visit or prescription.



Deductible*

This is the amount you'll need to pay for covered services before your plan begins to pay.



Co-insurance*

After you've paid your deductible, you'll only pay a percentage of each covered service.

Out-of-pocket limit

You'll never pay more than your out-of-pocket limit during the plan year. The out-of-pocket limit includes all of your co-payment, deductible and co-insurance payments.



If you go out of network, your costs may be higher. Out-of-network providers can even bill you for amounts higher than what your plan will cover.

For all of the **COVERAGE DETAILS**, see your official health plan documents.

Copay Plan



www.myuhc.com

BENEFITS		United Healthcare \$5000 / HRA	
	Network	Out-of-Network	
Deductible	\$3,500 / Single \$7,000 / Family	\$7,000 / Single \$14,000 / Family	
HRA - Applies after Employee pays \$2,500 / Single deductible and \$6,000 / Family Deductible.	\$1,000 following Employee Deductible \$1,000 following Family Deductible	N/A	
Coinsurance Reimbursement	100% Reimbursement	80% Reimbursement	
Out of Pocket Maximum	\$6,350 / Single \$12,700 / Family	\$16,350 / Single \$32,700 / Family	
<i>Includes Deductible, Medical Copays, Office Visit Copays, & RX Copays</i>			
Lifetime Maximum	Unlimited		
Physician Services			
• Office Visit	\$35 Copay	Deductible Applies	Deductible Applies
• Specialists	\$50 Copay		70% Reimbursement
• Virtual Visits	\$5 Copay		
• Routine Physicals	Deductible Waived; No Copays		
Inpatient Hospital Services			
• Facility	Deductible Applies	Deductible Applies	Deductible Applies
• Physician Services	100% Reimbursement	100% Reimbursement	70% Reimbursement
Outpatient Hospital Services			
• Facility	Deductible Applies	Deductible Applies	Deductible Applies
• Physician Services	100% Reimbursement	100% Reimbursement	70% Reimbursement
• Emergency Services	\$200 Copay	\$200 Copay	\$200 Copay
	100% Reimbursement	100% Reimbursement	100% Reimbursement
• Urgent Care Services	\$75 Copay	Deductible Applies	Deductible Applies
	100% Reimbursement	100% Reimbursement	70% Reimbursement
Maternity Services			
• Physician Office Visits	One Time Copay	Deductible Applies;	Deductible Applies;
• Hospital Services	Deductible Applies; 100% Reimbursement	70% Reimbursement	70% Reimbursement
Mental Health / Substance Abuse			
• Inpatient	Deductible Applies; 100% Reimbursement	Deductible Applies; 70% Reimbursement	Deductible Applies; 70% Reimbursement
• Outpatient	\$50 Copay	Same as Inpatient	Same as Inpatient
• Vision Exam	\$25 Copay / 1 Exam Every 2 Years	Deductible Applies; 80% Reimbursement	Deductible Applies; 80% Reimbursement
Prescription Drugs			
Tier 1			\$10
Tier 2			\$35
Tier 3			\$60
Tier 4			\$100



HRA Choice Plus Plan 604 / 05U Coverage Period: 03/01/2016 – 02/28/2017

Summary of Benefits and Coverage: What This Plan Covers & What it Costs Coverage for: Employee & Family Plan Type: HMO

 **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 welcometouhc.com or by calling 1-800-411-1143.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: \$3,500 Individual / \$7,000 Family Non-Network: \$7,000 Individual / \$14,000 Family Per calendar year. Copays, prescription drugs and services listed below as "No Charge" do not apply to 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?	Network: \$6,350 Individual / \$12,700 Family Non-Network: \$16,350 Individual / \$32,700 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.
What is not included in the out-of-pocket limit?	Premium , balance-billed charges, health care this plan doesn't 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 .
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 network providers , see myuhc.com or call 1-800-411-1143.	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 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 .

Questions: Call 1-800-411-1143 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCHIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.



HRA Choice Plus Plan 604 / 05U Coverage Period: 03/01/2016 –02/28/2017

Summary of Benefits and Coverage: What This Plan Covers & What it Costs Coverage for: Employee & Family Plan Type: HMO



- **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 a non-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-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 network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 copay per visit	30% co-ins after ded.	Virtual visits (Telehealth) – \$5 copay per visit by a designated virtual network provider. No virtual coverage out-of-network. If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Specialist visit	\$50 copay per visit	30% co-ins after ded.	If you receive services in addition to office visit, additional copays, deductibles, or co-ins may apply.
	Other practitioner office visit	\$25 copay per visit	30% co-ins after ded.	Cost share applies to manipulative (chiropractic) services only and is limited to 24 visits per calendar year. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Preventive care / screening / immunization	No Charge	Not Covered*	Includes preventive health services specified in the health care reform law. *Certain services are covered when using a non-network provider.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% co-ins after ded.	Pre-authorization is required non-network for sleep studies or benefit reduces to 50% of eligible expenses.
	Imaging (CT / PET scans, MRIs)	0% co-ins after ded.	30% co-ins after ded.	Pre- authorization is required non-network or benefit reduces to 50% of eligible expenses.



HRA Choice Plus Plan 604 / 05U

Coverage Period: 03/01/2016 – 02/28/2017

Summary of Benefits and Coverage: What This Plan Covers & What it Costs Coverage for: Employee & Family Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at myuhc.com</p>	Tier 1 – Your Lowest-Cost Option	Retail: \$10 copay Mail-Order: \$25 copay	Retail: \$10 copay	<p>Provider means pharmacy for purposes of this section.</p> <p>Retail: Up to a 31 day supply</p> <p>Mail-Order: Up to a 90 day supply</p> <p>You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us.</p> <p>Certain drugs may have a pre-authorization requirement or may result in a higher cost. If you use a non-network pharmacy (including a mail order pharmacy), you are responsible for any amount over the allowed amount.</p> <p>You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.</p> <p>Tier 1 contraceptives covered at No Charge.</p> <p>See the website listed for information on drugs covered by your plan. Not all drugs are covered.</p>
	Tier 2 – Your Midrange-Cost Option	Retail: \$35 copay Mail-Order: \$87.50 copay	Retail: \$35 copay	
	Tier 3 – Your Highest-Cost Option	Retail: \$60 copay Mail-Order: \$150 copay	Retail: \$60 copay	
	Tier 4 – Additional High-Cost Options	Retail: \$100 copay Mail-Order: \$250 copay	Retail: \$100 copay	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	0% co-ins after ded.	30% co-ins after ded.	<p>Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.</p>
	Physician / surgeon fees	0% co-ins after ded.	30% co-ins after ded.	
<p>If you need immediate medical attention</p>	Emergency room services	\$200 copay per visit	\$200 copay per visit	<p>None</p>
	Emergency medical transportation	0% co-ins after ded.	*0% co-ins after ded.	
	Urgent care	\$75 copay per visit	30% co-ins after ded.	
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	0% co-ins after ded.	30% co-ins after ded.	<p>If you receive services in addition to urgent care, additional copays, deductibles, or co-ins may apply.</p> <p>Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.</p>
	Physician / surgeon fees	0% co-ins after ded.	30% co-ins after ded.	



HRA Choice Plus Plan 604 / 05U Coverage Period: 03/01/2016 – 02/28/2017

Summary of Benefits and Coverage: What This Plan Covers & What it Costs Coverage for: Employee & Family Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
<p>If you have mental health, behavioral health, or substance abuse needs</p>	Mental / Behavioral health outpatient services	\$50 copay per visit	30% co-ins after ded.	Pre-authorization is required non-network for certain services or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
	Mental / Behavioral health inpatient services	0% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder outpatient services	\$50 copay per visit	30% co-ins after ded.	Pre-authorization is required non-network for certain services or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
	Substance use disorder inpatient services	0% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses. See your policy or plan document for additional information about EAP benefits.
<p>If you are pregnant</p>	Prenatal and postnatal care	No Charge	30% co-ins after ded.	Additional copays, deductibles, or co-ins may apply depending on services rendered.
	Delivery and all inpatient services	0% co-ins after ded.	30% co-ins after ded.	Inpatient pre-authorization may apply.
<p>If you need help recovering or have other special health needs</p>	Home health care	0% co-ins after ded.	30% co-ins after ded.	Limited to 60 visits per calendar year. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Rehabilitation services	\$25 copay per outpatient visit	30% co-ins after ded.	Limits per calendar year: physical, speech, occupational – 20 visits; cardiac – 36 visits; pulmonary – 20 visits. Pre-authorization required for physical, occupational and speech non-network or benefit reduces to 50% of eligible expenses.



HRA Choice Plus Plan 604 / 05U Coverage Period: 03/01/2016 –02/28/2017

Summary of Benefits and Coverage: What This Plan Covers & What it Costs Coverage for: Employee & Family Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Habilitative services	\$25 copay per outpatient visit	30% co-ins after ded.	Limits are combined with Rehabilitation Services limits listed above. Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Skilled nursing care	0% co-ins after ded.	30% co-ins after ded.	Limited to 60 days per calendar year (combined with inpatient rehabilitation). Pre-authorization is required non-network or benefit reduces to 50% of eligible expenses.
	Durable medical equipment	0% co-ins after ded.	30% co-ins after ded.	Pre-authorization is required non-network for DME over \$1,000 or benefit reduces to 50% of eligible expenses. Covers 1 per type of DME (including repair/replacement) every 3 years.
	Hospice service	0% co-ins after ded.	30% co-ins after ded.	Inpatient pre-authorization is required for non-network or benefit reduces to 50% of eligible expenses.
	If your child needs dental or eye care	Eye exam	Not Covered	Not Covered
Glasses		Not Covered	Not Covered	No coverage for glasses.
Dental check-up		Not Covered	Not Covered	No coverage for dental check-up.

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.)	
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery 	<ul style="list-style-type: none"> Dental care (Adult/Child) Glasses (Adult/Child) Infertility treatment
<ul style="list-style-type: none"> Routine eye care (Adult/Child) Routine foot care Weight loss programs 	<ul style="list-style-type: none"> Long-term care Non-emergency care when traveling outside the U.S. Private-duty nursing
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.)	
<ul style="list-style-type: none"> Chiropractic care 	<ul style="list-style-type: none"> Hearing aids



UnitedHealthcare

HRA Choice Plus Plan 604 / 05U Coverage Period: 03/01/2016 –02/28/2017

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Employee & Family **Plan Type:** HMO

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 1-866-747-1019. 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 Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Georgia Office of Insurance & Safety Fire Commissioner at 1-404-656-2070 or oci.ga.gov/home.aspx.

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 1-800-411-1143.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-411-1143.

Navajo (Dine): Dinek'ehgo shika at'ohwol minisingo, kwijigo holne' 1-800-411-1143.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-411-1143.

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



Coverage Examples

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.

HRA Choice Plus Plan 604 / 05U Coverage Period: 03/01/2016 –02/28/2017

Coverage for: Employee & Family Plan Type: HMO

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$3,820
- Patient pays \$3,720

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	\$3,500
Copays	\$20
Coinsurance	\$0
Limits or exclusions	\$200
Total	\$3,720

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

- Amount owed to providers: \$5,400
- Plan pays \$3,860
- Patient pays \$1,540

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	\$200
Copays	\$1,300
Coinsurance	\$0
Limits or exclusions	\$40
Total	\$1,540



Questions and answers about Coverage Examples:

<p>What are some of the assumptions behind the Coverage Examples?</p> <ul style="list-style-type: none"> • Costs don't include premiums. • Sample care costs are based on national averages supplied to 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. • If other than individual coverage, the Patient Pays amount may be more. 	<p>What does a Coverage Example show?</p> <p>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.</p> <p>Does the Coverage Example predict my own care needs?</p> <p>✘ 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.</p> <p>Does the Coverage Example predict my future expenses?</p> <p>✘ 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.</p>	<p>Can I use Coverage Examples to compare plans?</p> <p>✔ 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.</p> <p>Are there other costs I should consider when comparing plans?</p> <p>✔ 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.</p>
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Questions: Call 1-800-411-1143 or visit us at welcometouhc.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call the phone number above to request a copy.

MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE OMB 0938-0990 FOR USE ON OR AFTER APRIL 1, 2011 **CMS Form 10182-CC Updated April 1, 2011** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. 1

Important Notice from All American Quality Foods About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with United Healthcare and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. All American Quality Foods has determined that the prescription drug coverage offered by United Healthcare is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan. MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE

LANGUAGE OMB 0938-0990 FOR USE ON OR AFTER APRIL 1, 2011 **CMS Form 10182-CC Updated April 1, 2011** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. 2

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current All American Quality Foods coverage will be affected

Notice of Creditable/Non-Creditable Coverage: ALL AMERICAN QUALITY FOODS						
Rx Rider Number	Rx Description (Retail Cost Sharing)	Deductible Amount	Out-of- Pocket	IHDHP (Y/N)	Status if not an IHDHP or IHDHP and Medicare Secondary	Status if IHDHP Medicare Primary
5U	\$10/\$35/\$60/\$100]	0	n/a	N	Creditable	Creditable

If you do decide to join a Medicare drug plan and drop your current All American Quality Foods coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with All American Quality Foods and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information call Donna Butler at (770) 474-5904.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through All American Quality Foods

changes. You also may request a copy of this notice at any time. MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE OMB 0938-0990 FOR USE ON OR AFTER

APRIL 1, 2011 CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. 3

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

NOTICE LANGUAGE OMB 0938-0990 FOR USE ON OR AFTER APRIL 1, 2011 CMS

Contact--Position/Office: Donna Butler

Address: 125 Eagles Landing Parkway, Stockbridge, Ga 30281

Phone Number: (770) 474-5904



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