

**UFCW HEALTH CARE FUND  
SUMMARY PLAN DESCRIPTION  
PPO Plan Q (Alternative to Cobra) – Grandfathered  
JANUARY 1, 2012**

**GENERAL INFORMATION**

ELIGIBILITY – You will be eligible for benefits on the 4<sup>th</sup> contribution following your health care waiting (or qualifying) period indicated in the Health Care section of your Collective Bargaining Agreement. Separate eligibility applies to dental benefits. (See below.)

<p><b>Dependent Coverage</b></p> <p><b>Ages 19-26 – See language attached or contact Fund Office for eligibility guidelines. →</b></p>	<p><b>Coverage for Biological &amp; Adopted Children:</b> Up to age 26 years, provided a Dependent Eligibility Form is completed and returned to the Fund office.</p> <p><b><u>Exceptions</u></b> – Children between age 23 &amp; 26 who have access to health care coverage through their employer OR their spouse’s employer, are <b><u>NOT</u></b> eligible for coverage as a dependent of a Local One Health Care participant.</p> <p><b>Coverage for Step-Children &amp; Children for whom Participants are designated Legal Guardian:</b> Up to age 19 years, with coverage extended up to 23 years of age <b><u>IF</u></b> the Child is a college student and/or financially dependent on the participant.</p> <p><b>Eligibility for Dependents over age 19 years will be verified each year for continued coverage and includes providing certain documentation to the Fund office.</b></p>	
<p><b>Pre-Certification</b></p> <p><b>1-877-223-2993</b></p>	<p>Yes</p> <ul style="list-style-type: none"> <li>• Excellus: All Inpatient admissions – including maternity (except Inpatient Alcohol, Drug, Psychiatric). Includes home health, infusion therapy, Durable Medical Equipment over \$200, MRI, CAT scans, PET scans.</li> <li>• Your Baby and You Maternity.</li> <li>• Inpatient Alcohol, Drug, Psychiatric or Employee Assistance Program through Health Management Center – APS.</li> <li>• Penalty of \$500 or 50% whichever is less for <b>No Pre-Certification</b>.</li> </ul>	
COST SHARING EXPENSES	PPO In-Network	PPO Out-of Network
<b>Deductible</b>	\$1,000 individual	\$2,000 individual
<b>Deductible Carry-Over Y/N (October, November and December Carryover)</b>	Yes	Yes
<b>Co-payment</b>	\$20, except where noted	None
<b>Coinsurance</b>	20%, except where noted	40%, except where noted
<b>Annual Out-of-Pocket Maximum (includes deductible and coinsurance, excludes co-payment, excludes artificial insemination)</b>	\$4,000 individual	\$8,000 individual

<b>HOSPITAL INPATIENT SERVICES</b>	<b>PPO In-Network</b>	<b>PPO Out-of Network</b>
<b>Inpatient Hospital Services</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Maternity Care</b> (Mandated, 48 hrs regular delivery, 96 for c-section; one home care visit covered in full, not subject to any other home care visit limitations)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Newborn Nursery Care</b>	Coinsurance	Deductible/Coinsurance
<b>Internal Prosthetics</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Skilled Nursing Facility</b>	Deductible/Coinsurance (120 days per calendar year)	Deductible/Coinsurance (120 days per calendar year)
<b>Physical Rehabilitation</b>	Covered in Full 60 days per calendar year	Deductible/Coinsurance 60 days per calendar year
<b>Acute Mental Health Care</b> (Includes Day/Night Care: 2:1)	Deductible/Coinsurance 2 admissions per lifetime 30 days per calendar year	Deductible/Coinsurance 2 admissions per lifetime 30 days per calendar year
<b>Detoxification</b>	Deductible/Coinsurance 2 admissions per lifetime 7 days per calendar year	Deductible/Coinsurance 2 admissions per lifetime 7 days per calendar year
<b>Chemical Dependence and Abuse Rehabilitation</b>	Deductible/Coinsurance 2 admissions per lifetime 30 days per calendar year	Deductible/Coinsurance 2 admissions per lifetime 30 days per calendar year
<b>HOSPITAL OUTPATIENT SERVICES</b>	<b>PPO In-Network</b>	<b>PPO Out-of Network</b>
<b>Surgical Care including Surgicenters/Freestanding</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Diagnostic Imaging, X-ray, CAT, MRI, lab, pathology</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Mammogram Routine</b>	Covered in full	Deductible/Coinsurance
<b>Cervical Cytology (Pap Smear, does not include exam) ROUTINE</b>	Covered in full	Deductible/Coinsurance
<b>Cardiac Rehabilitation</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Radiation Therapy and Chemotherapy</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Physical, Speech, and Occupational Therapy</b>	Deductible/Coinsurance 45 visits per calendar year per each therapy <i>In/Out Combined</i>	Deductible/Coinsurance 45 visits per calendar year per each therapy <i>In/Out Combined</i>
<b>Mental Health Care</b>	50% Coinsurance 40 visits per calendar year <i>In/Out Combined</i>	Deductible / 50% Coinsurance 40 visits per calendar year <i>In/Out Combined</i>
<b>Chemical Dependency</b>	Deductible/Coinsurance – 60 visits Per Calendar Yr. – <i>In/Out Combined</i>	Deductible/Coinsurance – 60 visits Per Calendar Yr. – <i>In/Out Combined</i>
<b>Hemodialysis</b>	Deductible/Coinsurance	Deductible/Coinsurance

<b>Home Care</b>	\$50 Deductible/20% Coinsurance – unlimited visits	\$50 Deductible/25% Coinsurance – unlimited visits
<b>Hospice Care</b> (Includes 5 bereavement counseling visits)	Covered in full – unlimited visits	Covered in full – unlimited visits
<b>Respiratory Therapy</b>	Deductible/Coinsurance Unlimited Visits	Deductible/Coinsurance Unlimited Visits
<b>PHYSICIAN SERVICES/OFFICE VISITS</b>	<b>PPO In-Network</b>	<b>PPO Out-of Network</b>
<b>Routine Physical Examinations</b>	1 per calendar year – Covered in full	1 per calendar year – Covered in full
<b>Diagnostic Laboratory, X-ray and Pathology</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Well Child Visits and Immunizations</b> (mandated visits/immunizations full coverage, Including Gardasil (HPV) ages 9 – 26 yrs)	Covered in full	Covered in full
<b>Office Consultations</b>	Office Visit Co-Pay	Deductible/Coinsurance
<b>Specialist Office Visit</b>	\$30 Co-Payment	Deductible/Coinsurance
<b>Diagnostic GYN Visits</b>	Office Visit Co-Pay	Deductible/Coinsurance
<b>Diagnostic Office Visits</b>	Office Visit Co-Pay	Deductible/Coinsurance
<b>Routine GYN Visits including Pap Smear</b>	Covered In Full, including Lab	Deductible/Coinsurance
<b>Maternity Care</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>In-Hospital Physician Visits</b> (IHM for mastectomy must be covered for as long as attending physician deems medically necessary)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Respiratory Therapy</b>	Deductible/Coinsurance Unlimited visits	Deductible/Coinsurance Unlimited visits
<b>Anesthesia</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Second Medical Opinion</b>	Office Visit Co-Pay	Deductible/Coinsurance
<b>Prostate Cancer Screenings</b>	Office Visit Co-Pay	Deductible/Coinsurance
<b>Allergy Testing and Treatment</b> (injections are inclusive)	Office Visit Co-Pay (Testing) Treatment covered In full	Deductible/Coinsurance
<b>Adult Immunizations</b>	Flu Shot, Hepatitis A, B covered in full & Recommended Adult Immunizations by Schedule	Flu Shot, Hepatitis A, B covered in full & Recommended Adult Immunizations by Schedule
<b>Chiropractic Care</b>	Office Visit Co-Pay – 30 visits per year <i>In/Out Combined</i>	Deductible/Coinsurance–30 visits per yr <i>In/Out Combined</i>

ADDITIONAL BENEFITS	PPO In-Network	PPO Out-of Network
<b>Treatment of Diabetes</b> (Insulin & Supplies) <b>Education and DME</b> (30 day supply)	Office Visit Co-Pay	Deductible/Coinsurance
<b>Durable Medical Equipment (DME)</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>External Prosthetics/Orthotics</b> (Foot orthotics excluded)	Deductible/Coinsurance	Deductible/Coinsurance
<b>Medical Supplies</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Hearing Aids</b>	\$600 every 3 years no age limit	\$600 every 3 years no age limit
<b>Hearing Evaluations Diagnostic</b>	Office Visit Co-Pay	Deductible/Coinsurance
<b>Foot Orthotics</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Ambulance Service (Ground)</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Acupuncture</b>	50% coinsurance -10 visit maximum	50% coinsurance -10 visit maximum
<b>Facility – Emergency Room</b>	Covered in full \$150 Penalty for non-emergency	Covered in full (100% of Allowance) \$150 Penalty for non-emergency
<b>Freestanding Urgent Care Center</b>	\$25 Co-Pay	Deductible/Coinsurance

<b>Prescription Drug Benefit</b> (Including Oral Contraceptives)  <b>USE PRESCRIPTION DRUG CARD</b>	<p align="center"><b>Thirty (30) Day Supply from Retail Pharmacy</b>  <b>CO-PAYMENT - 20% Generic / 30% Brand / 50% Non-Preferred Brand*</b>  <b>Co-Pay Minimums \$15/30/55 – Co-Pay Maximums \$30/85/None</b></p> <p align="center"><i>Exception - Core Therapy Drugs limited to \$5 Co-Pay.</i></p> <p align="center"><b>Ninety (90) Day Supply from Mail Order OR Tops Markets &amp; Parkway Drugs</b>  <b>CO-PAYMENT - 20% Generic / 30% Brand / 50% Non-Preferred Brand*</b>  <b>Co-Pay Minimums \$30/60/140 – Co-Pay Maximums \$100/200/None</b></p> <p align="center"><i>Exception – Core Therapy Drugs limited to \$10 Co-Pay (30 day supply pharmacy - 90 day supply mail order.)</i></p> <p align="center"><b>NOTE: *Non-preferred brand drugs (drugs that have a generic available)</b></p>
<b>Vision Benefit</b>  <b>DAVIS VISION</b> (800) 999-5431	<p align="center">Up to \$140 maximum – including eyeglasses  ADULT - every 2 years  CHILD - every year  <b>*Individual Plan covers member only</b></p>
<b>Dental Benefit</b> > <b>General Dentistry Eligible upon 7th Contribution.</b>  > <b>Extensive Dentistry Eligible upon 13<sup>th</sup> Contribution.</b>	<p align="center">\$750.00 per participant per year  Preventative Care paid @ 100%. All other services paid at 90% of Fee Schedule  With 10% Co-Insurance paid by Member.</p> <p align="center">Paid out according to UFCW Fee Schedule</p> <p align="center"><b>* Any charges incurred due to extraction of wisdom teeth  Will be applied to the annual maximum</b>  Orthodontics - \$750.00 lifetime maximum (per participant)</p> <p align="center"><b>NOTE: No Dental Card – Submit ALL Dental Claims to UFCW  not Blue Cross &amp; Blue Shield</b></p>

