

**UFCW HEALTH CARE FUND
SUMMARY PLAN DESCRIPTION
Plan S PPO – Non-Grandfathered
Effective – January 1, 2011**

GENERAL INFORMATION

ELIGIBILITY - You will be eligible for benefits on the 4th 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>Dependent Coverage</p> <p>Ages 19-26 – See language attached or contact Fund Office for eligibility guidelines. →</p>	<p>Coverage for Biological & Adopted Children: Up to age 26 years, provided a Dependent Eligibility Form is completed and returned to the Fund office.</p> <p>Coverage for Step-Children & Children for whom Participants are designated Legal Guardian: Up to age 19 years, with coverage extended up to 23 years of age IF the Child is a college student and/or financially dependent on the participant.</p> <p>Eligibility for Dependents over age 19 years will be verified each year for continued coverage and requires providing certain documentation to the Fund office.</p>	
<p>Pre-Certification</p> <p>1-877-223-2993</p>	<p>Yes</p> <ul style="list-style-type: none"> • 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. • Great Beginnings Maternity program through Ullicare • Inpatient Alcohol, Drug, Psychiatric or Employee Assistance Program through Health Management Center • Penalty of \$500 or 50% whichever is less for No Pre-Certification. 	
COST SHARING EXPENSES	PPO In-Network	PPO Out-of Network
Deductible	\$600 individual / \$1,800 family	\$1,200 individual / \$3,600 family
Deductible Carry-Over Y/N (October, November and December Carryover)	Yes	Yes
Office Visit Co-payment	\$20, except where noted	Deductible/Coinsurance
Specialist Office Visit	\$30 Co-Payment	Deductible/Coinsurance
Coinsurance	20%, except where noted	40%, except where noted

Annual Out-of-Pocket Maximum (includes deductible and coinsurance, excludes co-payment, excludes artificial insemination)	\$3,000 individual / \$9,000 family	\$5,000 individual / \$15,000 family
HOSPITAL INPATIENT SERVICES	PPO In-Network	PPO Out-of Network
Inpatient Hospital Services	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Care (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
Skilled Nursing Facility	Deductible/Coinsurance (120 days per calendar year)	Deductible/Coinsurance (120 days per calendar year)
Physical Rehabilitation	Covered in Full 60 days per calendar year	Deductible/Coinsurance 60 days per calendar year
Acute Mental Health Care (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
Detoxification	Deductible/Coinsurance 2 admissions per lifetime 7 days per calendar year	Deductible/Coinsurance 2 admissions per lifetime 7 days per calendar year
Chemical Dependence and Abuse Rehabilitation	Deductible/Coinsurance 2 admissions per lifetime 30 days per calendar year	Deductible/Coinsurance 2 admissions per lifetime 30 days per calendar year
HOSPITAL OUTPATIENT SERVICES	PPO In-Network	PPO Out-of Network
Surgical Care including Surgicenters/Freestanding	Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Imaging, X-ray, CAT, MRI, lab, pathology	Deductible/Coinsurance	Deductible/Coinsurance
Mammogram Routine	Covered in full	Deductible/Coinsurance
Cervical Cytology (Pap Smear, does not include exam) ROUTINE	Covered in full	Deductible/Coinsurance
Cardiac Rehabilitation	Deductible/Coinsurance	Deductible/Coinsurance
Radiation Therapy and Chemotherapy	Deductible/Coinsurance	Deductible/Coinsurance
Physical, Speech, and Occupational Therapy	Deductible/Coinsurance 45 visits per calendar year per each therapy	Deductible/Coinsurance 45 visits per calendar year per each therapy

Mental Health Care	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>
Chemical Dependency	Deductible/Coinsurance – 60 visits	Deductible/Coinsurance – 60 visits
Home Care	\$50 Deductible/20% Coinsurance – unlimited visits	\$50 Deductible/25% Coinsurance – unlimited visits
Hospice Care (Includes 5 bereavement counseling visits)	Covered in full – unlimited visits	Covered in full – unlimited visits
PHYSICIAN SERVICES/OFFICE VISITS	PPO In-Network	PPO Out-of Network
Routine Physical Examinations	1 per calendar year – Covered in full	1 per calendar year – Covered in full
Diagnostic Laboratory, X-ray and Pathology	Deductible/Coinsurance	Deductible/Coinsurance
Well Child Visits and Immunizations (mandated visits/immunizations full coverage, including Gardasil (HPV) ages 9 – 26 yrs)	Covered in full	Covered in full
Office Consultations	Office Visit Copay	Deductible/Coinsurance
Diagnostic GYN Visits	Office Visit Copay	Deductible/Coinsurance
Diagnostic Office Visits	Office Visit Copay	Deductible/Coinsurance
Routine GYN Visits including Pap Smear	Covered In Full, including Lab	Deductible/Coinsurance
Maternity Care	Deductible/Coinsurance	Deductible/Coinsurance
In-Hospital Physician Visits (IHM for mastectomy must be covered for as long as attending physician deems medically necessary)	Deductible/Coinsurance	Deductible/Coinsurance
Respiratory Therapy	Deductible/Coinsurance Unlimited visits	Deductible/Coinsurance Unlimited visits
Anesthesia	Deductible/Coinsurance	Deductible/Coinsurance
Second Medical Opinion	Office Visit Copay	Deductible/Coinsurance
Prostate Cancer Screenings	Office Visit Copay	Deductible/Coinsurance
Allergy Testing and Treatment (injections are inclusive)	Office Visit Copay (Testing) Treatment covered in full	Deductible/Coinsurance
Adult Immunizations	Flu Shot, Hepatitis A, B covered in full	Flu Shot, Hepatitis A, B covered in full
Chiropractic Care	Office Visit Copay – 30 visits	Deductible/Coinsurance – 30 visits
ADDITIONAL BENEFITS	PPO In-Network	PPO Out-of Network

Treatment of Diabetes (Insulin & Supplies) Education and DME (30 day supply)	Office Visit Copay	Deductible/Coinsurance
Durable Medical Equipment (DME)	Deductible/Coinsurance	Deductible/Coinsurance
External Prosthetics/Orthotics (Foot orthotics excluded)	Deductible/Coinsurance	Deductible/Coinsurance
Medical Supplies	Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids	\$600 every 3 years no age limit	\$600 every 3 years no age limit
Foot Orthotics	Deductible/Coinsurance	Deductible/Coinsurance
Ambulance Service (Ground)	Deductible/Coinsurance	Deductible/Coinsurance
Acupuncture	50% coinsurance -10 visit maximum	50% coinsurance -10 visit maximum
Facility – Emergency Room	Covered in full \$150 penalty for non-emergency	Covered in full \$150 penalty for non-emergency
Freestanding Urgent Care Center	\$25 Copay	Deductible/Coinsurance
Prescription Drug Benefit (Including Oral Contraceptives) USE PRESCRIPTION DRUG CARD	<p align="center">Thirty (30) Day Supply from Retail Pharmacy CO-PAYMENT - 20% Generic / 30% Brand / 50% Non-Preferred Brand* Co-Pay Minimums \$15/30/55 – Co-Pay Maximums \$30/85/None</p> <p align="center"><i>Exception - Core Therapy Drugs limited to \$5 Co-Pay.</i></p> <p align="center">Ninety (90) Day Supply from Mail Order OR Tops Markets & Parkway Drugs CO-PAYMENT - 20% Generic / 30% Brand / 50% Non-Preferred Brand* Co-Pay Minimums \$30/60/140 – Co-Pay Maximums \$100/200/None</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>NOTE: *Non-preferred brand drugs (drugs that have a generic available)</p>	
Vision Benefit DAVIS VISION (800) 999-5431	<p align="center">Up to \$140 maximum – including eyeglasses ADULT - every 2 years CHILD - every year *Individual Plan covers member only</p>	
Dental Benefit > General Dentistry Eligible upon 7th Contribution. > Extensive Dentistry Eligible upon 13 th Contribution.	<p align="center">\$1,000 per participant per year Preventative Care paid @ 100%. All other services paid at 90% of Fee Schedule With 10% Co-Insurance paid by Member. \$2,000 family maximum</p> <p align="center">Paid out according to UFCW Fee Schedule</p> <p align="center">NOTE: Any charges incurred due to extraction of wisdom teeth will be applied to the annual maximum. Orthodontics - \$750 lifetime maximum (per participant)</p> <p align="center">NOTE: No Dental Card – Submit ALL Dental Claims to UFCW Local One Fund Office, not to Blue Cross & Blue Shield</p>	

<p>Life Insurance</p> <p>Based on years of continuous eligibility under the plan.</p> <p>When you leave, your death benefit coverage will continue during the balance of the month in which your employment terminates <i>plus</i> one more month.</p>	<p><i>Full-Time:</i></p> <p>Less than 16yrs \$25,000</p> <p>16-19yrs \$30,000</p> <p>20-24yrs \$40,000</p> <p>25yrs plus \$50,000</p>	<p><i>Part-Time:</i></p> <p>Less than 16yrs \$10,000</p> <p>16-19yrs \$15,000</p> <p>20-24yrs \$20,000</p> <p>25yrs plus \$25,000</p>
<p>Accidental Death</p>	<p>Follows same schedule as above</p>	
<p>Dependent Life Insurance (Family Coverage)</p>	<p>FT Coverage - Spouse - \$2,000 Child - \$2,000 PT Coverage - \$1,000 if purchasing Family Coverage</p>	