

**UFCW HEALTH CARE FUND
SUMMARY PLAN DESCRIPTION
PPO Plan R
EFFECTIVE: January 1, 2009**

GENERAL INFORMATION

ELIGIBILITY – You will be eligible for your benefits on the 4th contribution following your probationary period. Separate eligibility applies to your dental benefits. (See Below)

Dependent Coverage	Dependents to Age 19 Age – 19 to 23 Need to Qualify with Fund Office	
Pre-Certification	Yes <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. • Your Baby and You Maternity program through Care Guide. • Inpatient Alcohol, Drug, Psychiatric or Employee Assistance Program through Health Management Center • \$500 or 50% whichever is less (No Pre-Certification) 	
COST SHARING EXPENSES	PPO In-Network	PPO Out-of Network
Deductible	\$200 individual / \$600 family	\$400 individual / \$1,200 family
Deductible Carry-Over Y/N (October, November and December Carryover)	Yes	Yes
Office Visit Co-payment	\$10, except where noted	None
Specialist Office Visit	\$20 Co-Payment	Deductible/Coinsurance
Coinsurance	10%, except where noted	30%, except where noted
Annual Out-of-Pocket Maximum (includes deductible and coinsurance, excludes co-payment, excludes artificial insemination)	\$1,000 individual / \$3,000 family	\$2,000 individual / \$6,000 family
Lifetime Benefit Maximum	\$1,000,000	
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

Newborn Nursery Care	Coinsurance	Deductible/Coinsurance
Internal Prosthetics	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 Per Calendar Year	Deductible/Coinsurance – 60 visits Per Calendar Year
Home Care	\$50 Deductible/20% Coinsurance – unlimited visits	\$50 Deductible/25% Coinsurance – unlimited visits
Hemodialysis	Deductible/Coinsurance	Deductible/Coinsurance
Hospice Care (Includes 5 bereavement counseling visits)	Covered in full – unlimited visits	Covered in full – unlimited visits
Respiratory Therapy	Deductible/Coinsurance Unlimited Visits	Deductible/Coinsurance 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 Co-Pay	Deductible/Coinsurance
Diagnostic GYN Visits	Office Visit Co-Pay	Deductible/Coinsurance
Diagnostic Office Visits	Office Visit Co-Pay	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 Co-Pay	Deductible/Coinsurance
Prostate Cancer Screenings	Office Visit Co-Pay	Deductible/Coinsurance
Allergy Testing and Treatment (injections are inclusive)	Office Visit Co-Pay (Testing) Treatment covered In full	Deductible/Coinsurance
Adult Immunizations	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
Chiropractic Care	Office Visit Co-Pay – 30 visits per calendar year	Deductible/Coinsurance – 30 visits per calendar year
ADDITIONAL BENEFITS	PPO In-Network	PPO Out-of Network
Treatment of Diabetes (Insulin & Supplies) Education and DME (30 day supply)	Office Visit Co-Pay	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
Hearing Evaluations Diagnostic	Office Visit Co-Pay	Deductible/Coinsurance
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 \$50 penalty for non-emergency	Covered in full \$50 penalty for non-emergency
Freestanding Urgent Care Center	\$25 Co-Pay	Deductible/Coinsurance

<p>Prescription Drug Benefit (Including Oral Contraceptives) USE PRESCRIPTION DRUG CARD</p>	<p style="text-align: center;">Retail: Co-payment \$12 Generic / \$20 Brand / \$40 Non-Preferred Brand* <i>Exception - Core Therapy Drugs limited to \$5 Co-Pay.</i></p> <p style="text-align: center;">Mail Order: \$24 Generic / \$40 Brand / \$100 Non-Preferred Brand* <i>Exception – Core Therapy Drugs limited to \$10 Co-Pay (30 day supply pharmacy - 90 day supply mail order.)</i></p> <p style="text-align: center;">NOTE: *Non-preferred brand drugs (drugs that have a generic available) will now be subject to a \$40.00 co-pay at retail and \$100.00 co-pay at mail order (3-month supply)</p>
<p>Vision Benefit DAVIS VISION (800) 999-5431</p>	<p style="text-align: center;">Up to \$135 maximum – including eyeglasses ADULT - every 2 years CHILD - every year</p> <p style="text-align: center;">*Individual Plan covers member only</p>
<p>Dental Benefit ➤ General Dentistry Eligible upon 7th Contribution.</p> <p>➤ Extensive Dentistry Eligible upon 13th Contribution.</p>	<p style="text-align: center;">\$1,850 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 style="text-align: center;">Paid out according to UFCW Fee Schedule</p> <p style="text-align: center;">NOTE: Any charges incurred due to extraction of wisdom teeth will be applied to the annual maximum.</p> <p style="text-align: center;">Orthodontics - \$1,500 lifetime maximum (per participant) NOTE: No Dental Card – Submit ALL Dental Claims to UFCW not 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 (over 14 days old) PT Coverage - \$1,000 if purchasing Family Coverage</p>	
<p>Education/Scholarship</p>	<p>Industry related classes paid up to \$400 \$1,000 average college scholarship (Eligibility rules applies)</p>	