

**UFCW HEALTH CARE FUND
SUMMARY PLAN DESCRIPTION
Plan S PPO
Effective – January 1, 2009**

GENERAL INFORMATION

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. • Great Beginnings Maternity program through Ullicare • Inpatient Alcohol, Drug, Psychiatric or Employee Assistance Program through Health Management Center • \$500 or 50% whichever is less 	
COST SHARING EXPENSES	PPO In-Network	PPO Out-of Network
Deductible	\$300 individual / \$900 family	\$600 individual / \$1,200 family
Deductible Carry-Over Y/N (October, November and December Carryover)	Yes	Yes
Office Visit Co-payment	\$15, except where noted	Deductible/Coinsurance
Specialist Office Visit	\$25 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)	\$1,500 individual / \$3,000 family	\$3,000 individual / \$9,000 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
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 \$100 penalty for non-emergency	Covered in full \$100 penalty for non-emergency
Freestanding Urgent Care Center	\$25 Copay	Deductible/Coinsurance

Prescription Drug Benefit (Including Oral Contraceptives) USE PRESCRIPTION DRUG CARD	<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>
Vision Benefit DAVIS VISION (800) 999-5431	<p style="text-align: center;">Up to \$135 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 13th Contribution.	<p style="text-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 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 - \$750 lifetime maximum (per participant)</p> <p style="text-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 style="text-align: center;"><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 style="text-align: center;"><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 style="text-align: center;">Follows same schedule as above</p>	
<p>Dependent Life Insurance (Family Coverage)</p>	<p style="text-align: center;">FT Coverage - Spouse - \$2,000 Child - \$2,000 (over 14 days old) PT Coverage - \$1,000 if purchasing Family Coverage</p>	