



**SUMMARY PLAN DESCRIPTION**

**PPO Plan**

**EFFECTIVE: January 1, 2021**

**R**

<p><b>DEPENDENT COVERAGE</b></p>	<p><b>Coverage for Biological &amp; Adopted Children:</b> Up to age 26 years.</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>IF</b> the Child is a college student and/or financially dependent on the participant.</p>	
<p><b>PRE-CERTIFICATION</b></p> <p><b>1-800-363-4658</b></p>	<p>YES</p> <ul style="list-style-type: none"> <li>• Excellus: All Inpatient admissions – including maternity. Also Includes home health, infusion therapy, Durable Medical Equipment over \$200, MRI, CAT scans, PET scans.</li> <li>• Healthy Baby Connection (Maternity Program)</li> <li>• Inpatient Alcohol, Drug, Psychiatric or Employee Assistance Program through Health Management Concepts - HMC</li> <li>• Penalty of \$500 or 50% whichever is less for <b>No Pre-Certification</b>.</li> </ul>	
<p><b>Excellus Blue Cross Blue Shield</b></p> <p><b>MEDICAL INQUIRES</b></p>	<p><b>Dedicated Customer Care Line</b></p> <p><b>1-877-223-2993</b></p>	
<p><b>COST SHARING EXPENSES</b></p>	<p><b>PPO In-Network</b></p>	<p><b>PPO Out-of Network</b></p>
<p>Deductible w/ Wellness Incentive</p>	<p>\$300 individual / \$900 family</p>	<p>\$400 individual / \$1,200 family</p>
<p>Deductible w/o Wellness Incentive</p>	<p>\$400 individual / \$1,200 family</p>	<p>\$400 individual / \$1,200 family</p>
<p>Deductible Carry-Over Y/N (October, November and December Carryover)</p>	<p>Yes</p>	<p>Yes</p>
<p>Office Visit Co-payment w/ Wellness Incentive</p>	<p>\$10, except where noted</p>	<p>Deductible/Coinsurance</p>
<p>Office Visit Co-Payment w/o Wellness Incentive</p>	<p>\$12, except where noted</p>	<p>Deductible/Coinsurance</p>
<p>Specialist Office Visit w/ Wellness Incentive</p>	<p>\$20 except where noted</p>	<p>Deductible/Coinsurance</p>
<p>Specialist Office Visit Co-Payment w/o Wellness Incentive</p>	<p>\$25, except where noted</p>	<p>Deductible/Coinsurance</p>
<p><b>MDLIVE (Telemedicine) –24/7</b>  <b>TEXT – EXCELLUS to 635483</b>  <b>Or REGISTER/LOG IN AT:</b>  <a href="http://ExcellusBCBS.com/Member">ExcellusBCBS.com/Member</a></p>	<p><b>No Co-Pay</b></p> <p><i>24/7 Access to a Doctor</i></p>	



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Coinsurance with and without Wellness Incentive	20%, except where noted	30%, except where noted
Annual Out-of-Pocket Maximum w/ Wellness Incentive  (includes deductible, coinsurance and co-payment, excludes artificial insemination)	Medical: \$1,500 individual / \$4,500 family  Pharmacy: \$2,600 individual / \$5,700 family	\$2,000 individual / \$6,000 family
Annual Out-of-Pocket Maximum w/o Wellness Incentive  (includes deductible, coinsurance and co-payment, excludes artificial insemination)	Medical: \$2,000 individual / \$6,000 family  Pharmacy: \$2,600 individual / \$5,700 family	\$2,000 individual / \$6,000 family
<b>HOSPITAL INPATIENT SERVICES</b>	<b>PPO In-Network</b>	<b>PPO Out-of Network</b>
Inpatient Hospital Services	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Care <small>(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)</small>	Deductible/Coinsurance	Deductible/Coinsurance
Newborn Nursery Care	Coinsurance	Deductible/Coinsurance
Internal Prosthetics	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility <small>(Limit applies to IN and OUT of Network)</small>	Deductible/Coinsurance (120 days per calendar year)	Deductible/Coinsurance (120 days per calendar year)
Physical Rehabilitation <small>(Limit applies to IN and OUT of Network)</small>	Covered in Full 60 days per calendar year	Deductible/Coinsurance 60 days per calendar year
Acute Mental Health Care <small>(Includes Day/Night Care)</small>	Deductible/Coinsurance	Deductible/Coinsurance
Detoxification	Deductible/Coinsurance	Deductible/Coinsurance
Chemical Dependence and Abuse Rehabilitation	Deductible/Coinsurance	Deductible/Coinsurance
<b>HOSPITAL OUTPATIENT SERVICES</b>	<b>PPO In-Network</b>	<b>PPO Out-of Network</b>
Surgical Care including Surgicenters/Freestanding	Deductible/Coinsurance	Deductible/Coinsurance



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**PPO Plan**

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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 <i>(Limit applies to IN and OUT of Network)</i>	Deductible/Coinsurance 45 visits per calendar year per each therapy	Deductible/Coinsurance 45 visits per calendar year per each therapy
Mental Health Care	Office Visit Co-Pay	Deductible/Coinsurance
Chemical Dependency	Office Visit Co-Pay	Deductible/Coinsurance
Home Care	\$50 Deductible/20% Coinsurance – unlimited visits	\$50 Deductible/25% Coinsurance – unlimited visits
Hemodialysis	Deductible/Coinsurance	Deductible/Coinsurance
<b>PHYSICIAN SERVICES/OFFICE VISITS</b>	<b>PPO In-Network</b>	<b>PPO Out-of Network</b>
Hospice Care <i>(Includes 5 bereavement counseling visits)</i>	Covered in full – unlimited visits	Covered in full – unlimited visits
Respiratory Therapy	Deductible/Coinsurance	Deductible/Coinsurance
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 <i>(mandated visits/immunizations full coverage, including Gardasil (HPV))</i>	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



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**R**

**EFFECTIVE: January 1, 2021**

<b>Routine GYN Visits including Pap Smear – NO AGE LIMIT</b> One exam per year	Covered In Full, including Lab	Deductible/Coinsurance
<b>Pre-Natal Care, HCR Essential Service &amp; Preventive Service</b> <i>Includes Gestational Diabetes Screenings, HPV Testing &amp; HIV Testing and Counseling.</i>	Covered in Full	Deductible/Coinsurance
<b>In-Hospital Physician Visits</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Respiratory Therapy</b>	Deductible/Coinsurance	Deductible/Coinsurance
<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>	Office Visit Co-Pay (Testing) Treatment covered In full	Deductible/Coinsurance
<b>Adult Immunizations</b> <i>Flu Shots, FluMist, Hepatitis A,B, Tetanus, Diptheria, (TD) Measles, Mumps, Rubella (MMR), Varicella, Pneumococcal (polysaccharide) &amp; Meningococcal Immunizations, H1N1, HPV (Gardasil-3 doses), Rotavirus (Rotateq), Zostavax</i>	Covered in Full	Covered in Full
<b>Chiropractic Care</b> <i>(Limit applies to IN and OUT of Network)</i>	Office Visit Co-Pay – 30 visits per calendar year	Deductible/Coinsurance – 30 visits per calendar year
<b>ADDITIONAL BENEFITS</b>	<b>PPO In-Network</b>	<b>PPO Out-of Network</b>
<b>Treatment of Diabetes</b> <i>(Insulin &amp; Supplies)</i> <b>Education and DME</b> <i>(30 day supply)</i>	Office Visit Co-Pay	Deductible/Coinsurance



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**PP0 Plan**

**R**

**EFFECTIVE: January 1, 2021**

<b>Durable Medical Equipment (DME)</b> (Precertification applies if over \$200)	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> (Limit applies to In and Out of Network)	\$1,500 total – Limited to a single purchase (including repair & replacement) every 3 years. No age limit.	\$1,500 total – Limited to a single purchase (including repair & replacement) every 3 years. No age limit.
<b>Hearing Evaluations Diagnostic</b>	Specialist Visit Co-Pay	Deductible/Coinsurance
<b>Foot Orthotics</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Ambulance Service (Ground)</b>	Covered in Full	100% of allowable charge. If life threatening or no In-Network Provider available, then covered in full.
<b>Ambulance Service (Air)</b>	Fund's scheduled allowance when Medically Necessary	Fund's scheduled allowance when Medically Necessary
<b>Acupuncture</b> (Limit applies to In and Out of Network)	50% coinsurance -10 visit maximum	50% coinsurance -10 visit maximum
<b>Facility – Emergency Room</b>	Covered in full \$200 penalty for non-emergency	Covered in full \$200 penalty for non-emergency
<b>Freestanding Urgent Care Center</b>	\$25 Co-Pay	Deductible/Coinsurance
<b>Autism Applied Behavior Analysis</b> (Physician medical services only)	Specialist Co-Pay	Deductible/Coinsurance
<b>Autism Assistive Communication Devices (ACD)</b>	Specialist Co-Pay	Deductible/Coinsurance

**ADDITIONAL BENEFITS**



**SUMMARY PLAN DESCRIPTION**  
**PP0 Plan**  
**EFFECTIVE: January 1, 2021**

**R**

<p><b>EMPLOYEE MEMBER ASSISTANCE PROGRAM</b></p> <p><b>Call ▷ 1-866-269-7357</b></p> <p><b>Or Log On To:</b>  <a href="https://hmc.personaladvantage.com">https://hmc.personaladvantage.com</a>  <b>Code: LOCALONE</b></p>	<p><b>Free Services – 24/7</b></p> <p>Whatever the Stress: Relationships/Family, Work, Alcohol/Drugs, Anxiety, Depression, Finances, Grief, Aging Parents, Legal</p> <p>ALSO INCLUDES – Up to 5 FREE Counseling Sessions</p>
<p><b>VISION BENEFIT</b></p> <p><b>DAVIS VISION</b>  <b>(800) 999-5431</b> or  <a href="http://www.davisvision.com">www.davisvision.com</a></p>	<p><u>General Benefit:</u> Up to \$150.00 maximum – including eyeglasses  ADULT - every 2 years  CHILD – every year  *Individual Plan covers member only</p> <p><i>Safety Glasses: Annual benefit for those members who need them for work</i></p>
<p><b>DENTAL BENEFIT</b></p> <p>ALL Dental Claims should be submitted to The Loomis Company for processing and Payment. Claims can be submitted by your dental provider or by you directly to:</p> <p><b>The Loomis Company</b>  <b>P.O. Box 7011</b>  <b>Wyomissing, PA 19610-6011</b>  <b>Or Visit their Website at</b>  <a href="http://www.loomisco.com">www.loomisco.com</a></p> <p><i>For questions regarding your claim(s), please call the Health Care Fund Claims Service Unit at</i>  <b>1-800-959-9497</b></p> <p>A LIST OF IN-NETWORK PROVIDERS CAN BE FOUND AT: <a href="http://www.ufcwone.org">www.ufcwone.org</a></p>	<p><b>Maximum Benefit:</b> \$1,850 per Participant per year  <b>Preventative Care:</b> Paid @ 100% of Fee Schedule  <b>All Other Services:</b> Paid at 90% of Fee Schedule With 10% Co-Insurance paid by Member.</p> <p><i>Orthodontics - \$2,000 per lifetime maximum</i></p> <p><b>NOTE: Any charges incurred due to extraction of wisdom teeth will be applied to the annual maximum</b></p> <p><i>General Dentistry - Eligible upon 7th Contribution.</i>  <i>Extensive Dentistry – Eligible upon 13th Contribution.</i></p>



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**R**

**PRESCRIPTION DRUG BENEFIT**

**HealthSmart** Rx Solutions  
**Customer Service**  
**1-800-681-6912**

FOR SPECIALTY DRUGS  
 LOG ONTO [www.Accredo.com](http://www.Accredo.com)  
 Or call 1-800-803-2523

\*\* A LIST OF CORE THERAPY DRUGS  
 CAN BE FOUND AT [www.ufcwone.org](http://www.ufcwone.org)

ORDER YOUR DIABETIC SUPPLIES (*No Co-Pays*)  
**1-877-316-2460**  
 Or ONLINE at  
[www.onesourceng.com](http://www.onesourceng.com)

**CO-PAYMENT – WITH Wellness Incentive**

**30 Day Supply**

GENERIC	BRAND	Non-PREFERRED BRAND
10% (Min. \$15 – Max \$25)	20% (Min. \$30 – Max \$50)	50% (Min. \$50 – Max \$100)

**90 Day Supply**

GENERIC	BRAND	Non-PREFERRED BRAND
10% (Min. \$40 – Max \$70)	20% (Min. \$85 – Max \$125)	50% (Min. \$125 – Max \$200)

**\*\*Exception - Core Therapy Drugs limited to \$10 Co-Pay.**  
**Ninety (90) Day Supply from Mail Order OR Tops Markets & Parkway Drugs**

**CO-PAYMENT – WITHOUT Wellness Incentive**

**30 Day Supply**

GENERIC	BRAND	Non-PREFERRED BRAND
15% (Min. \$15 – Max \$25)	25% (Min. \$30 – Max \$50)	50% (Min. \$50 – Max \$100)

**90 Day Supply**

GENERIC	BRAND	Non-PREFERRED BRAND
15% (Min. \$40 – Max \$70)	25% (Min. \$85 – Max \$125)	50% (Min. \$125 – Max \$200)

**\*\*Exception – Core Therapy Drugs limited to \$15 Co-Pay**  
**NOTE: \*Non-preferred brand drugs (drugs that have a generic available)**

*Generic Oral Contraceptives: No Co-Pay with prescription*

**LIFE INSURANCE**  
 Based on years of continuous eligibility under the plan.

When you leave, your death benefit coverage will continue during the balance of the month in which your employment terminates *plus* one more month.

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**NOTE: MEMBERS HIRED ON OR AFTER 1/1/2018**

*Age 65 – 35% Reduction*

*Age 70 – 50% Reduction*

*Applies to both full-time and part-time employees.*

<i>Full-Time:</i>	<i>Part-Time:</i>
Less than 16yrs	Less than 16yrs
\$25,000	\$10,000
16-19yrs	16-19yrs
\$30,000	\$15,000
20-24yrs	20-24yrs
\$40,000	\$20,000
25yrs plus	25yrs plus
\$50,000	\$25,000



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<b>Accidental Death</b>	Follows same schedule as above
<b>Dependent Life Insurance (Family Coverage)</b>	FT Coverage - Spouse - \$2,000 Child - \$2,000 PT Coverage - \$1,000 if purchasing Family Coverage
<b>Education/Scholarship</b>	Industry related classes paid up to \$400 \$1,000 average college scholarship (Eligibility rules applies)

**Does this Coverage Provide Minimum Essential Coverage?** Since your coverage under the Fund’s Plan R meets this requirement, you will **NOT** pay a penalty in connection with the ACA’s Individual Mandate, as long as you remain covered under Plan R during 2021.

**Does this Coverage Meet the Minimum Value Standard?** The ACA rates health plans available through the state Exchanges by assigning them a “metal” category, based on the average percentage of covered health costs payable by the plan. Bronze plans have a minimum value standard of 60%, Silver plans have a minimum value of 70%, Gold plans have a minimum value of 80% and Platinum plans have a minimum value of 90%. **The Fund’s consultant has determined that your coverage under Plan R is the equivalent of a Gold plan on the state Exchange.**

**Helpful WEBSITE Links**

- UFCW Local One Health Care Fund - [www.ufcwone.org](http://www.ufcwone.org)
- HealthSmart Rx (Express Scripts) - [www.express-scripts.com](http://www.express-scripts.com)
- Excellus Blue Cross Blue Shield - [www.excellusbcbs.com/UFCWONE](http://www.excellusbcbs.com/UFCWONE)
- Davis Vision - [www.davisvision.com](http://www.davisvision.com)
- Specialty Drugs (Accredo) - [www.accredo.com](http://www.accredo.com)
- Diabetic Supplies (One Health) - [www.onesourcecmg.com](http://www.onesourcecmg.com)
- MDLIVE (Telemedicine) - [www.ExcellusBCBS.com/Member](http://www.ExcellusBCBS.com/Member)
- Employee Member Assistance Program - <https://hmc.personaladvantage.com/LOCALONE>
- Quit For Life (Tobacco Cessation) WELLFRAME - [www.wellframe.com/download](http://www.wellframe.com/download)

**TOLL FREE - Contact Numbers**

- Medical Claims – Excellus BCBS - 1-877-223-2993
- UFCW Benefit Funds Office - 1-800-959-9497
- Nurse Help Line - 1-800-348-9786
- Employee Member Assistance Program - 1-866-269-7357
- Davis Vision - 1-800-999-5431
- Maternity Program - 1-877-222-1240
- One Health (Diabetic Supplies) - 1-877-316-2460
- HealthSmart Rx (Prescription Mail Order) - 1-800-681-6912
- Accredo (Specialty Drugs) - 1-800-803-2523