



SUMMARY PLAN DESCRIPTION

PPO Plan

EFFECTIVE: January 1, 2021

U

<p>DEPENDENT COVERAGE</p>	<p>Coverage for Biological & Adopted Children: Up to age 26 years.</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>PRE-CERTIFICATION</p> <p>1-800-363-4658</p>	<p>YES</p> <ul style="list-style-type: none"> • Excellus: All Inpatient admissions – including maternity. Also Includes home health, infusion therapy, Durable Medical Equipment over \$200, MRI, CAT scans, PET scans. • Healthy Baby Connection (Maternity Program) • Inpatient Alcohol, Drug, Psychiatric or Employee Assistance Program through Health Management Concepts - HMC • Penalty of \$500 or 50% whichever is less for No Pre-Certification. 	
<p>Excellus Blue Cross Blue Shield</p> <p>MEDICAL INQUIRES</p>	<p>Dedicated Customer Care Line</p> <p>1-877-223-2993</p>	
<p>COST SHARING EXPENSES</p>	<p>PPO In-Network</p>	<p>PPO Out-of Network</p>
<p>Deductible w/ Wellness Incentive</p>	<p>\$400 individual / \$1,200 family</p>	<p>\$800 individual / \$2,400 family</p>
<p>Deductible w/o Wellness Incentive</p>	<p>\$500 individual / \$1,500 family</p>	<p>\$800 individual / \$2,400 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>\$12, except where noted</p>	<p>Deductible/Coinsurance</p>
<p>Office Visit Co-payment w/o Wellness Incentive</p>	<p>\$15, except where noted</p>	<p>Deductible/Coinsurance</p>



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COST SHARING EXPENSES	PPO In-Network	PPO Out-of Network
Specialist Office Visit w/ Wellness Incentive	\$25 except where noted	Deductible/Coinsurance
Specialist Office Visit w/o Wellness Incentive	\$30 except where noted	Deductible/Coinsurance
MDLIVE (Telemedicine) –24/7 TEXT – EXCELLUS to 635483 Or REGISTER/LOG IN AT: ExcellusBCBS.com/Member	No Co-Pay <i>24/7 Access to a Doctor</i>	
Coinsurance with and without Wellness Incentive	20%, except where noted	40%, except where noted
Annual Out-of-Pocket Maximum w/ Wellness Incentive (includes deductible, coinsurance and co-payment, excludes artificial insemination)	<u>Medical:</u> \$2,000 individual / \$6,000 family <u>Prescription Drugs:</u> \$2,600 individual/\$5,700 family	\$5,000 individual / \$15,000 family
Annual Out-of-Pocket Maximum w/o Wellness Incentive (includes deductible, coinsurance and co-payment, excludes artificial insemination)	<u>Medical:</u> \$2,500 individual / \$7,500 family <u>Prescription Drugs:</u> \$2,600 individual/\$5,700 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
Newborn Nursery Care	Coinsurance	Deductible/Coinsurance
Internal Prosthetics	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility (Limit applies to IN and OUT of Network)	Deductible/Coinsurance (120 days per calendar year)	Deductible/Coinsurance (120 days per calendar year)
Physical Rehabilitation (Limit applies to IN and OUT of Network)	Covered in Full 60 days per calendar year	Deductible/Coinsurance 60 days per calendar year



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Acute Mental Health Care (Includes Day/Night Care)	Deductible/Coinsurance	Deductible/Coinsurance
Detoxification	Deductible/Coinsurance	Deductible/Coinsurance
Chemical Dependence and Abuse Rehabilitation	Deductible/Coinsurance	Deductible/Coinsurance
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 <i>(Limit applies to IN and OUT of Network)</i>	Deductible/Coinsurance 30 visits per calendar year per each therapy	Deductible/Coinsurance 30 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
Hospice Care (Includes 5 bereavement counseling visits)	Covered in full – unlimited visits	Covered in full – unlimited visits
Respiratory Therapy	Deductible/Coinsurance	Deductible/Coinsurance
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 <i>(mandated visits/immunizations full coverage, Including Gardasil (HPV))</i>	Covered in full	Covered in full
Office Consultations	Office Visit Co-Pay	Deductible/Coinsurance



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



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Durable Medical Equipment (DME) <i>(Precertification applies if over \$200)</i>	Deductible/Coinsurance	Deductible/Coinsurance
External Prosthetics/Orthotics <i>(Foot orthotics excluded)</i>	Deductible/Coinsurance	Deductible/Coinsurance
Medical Supplies	Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids <i>(Limit applies to In and Out of Network)</i>	\$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.
Hearing Evaluations Diagnostic	Specialist Co-Pay	Deductible/Coinsurance
Foot Orthotics	Deductible/Coinsurance	Deductible/Coinsurance
Ambulance Service (Ground)	Covered in Full	100% of allowable charge. If life threatening or no In-Network Provider available, then covered in full.
Ambulance Service (Air)	Fund's scheduled allowance when Medically Necessary	Fund's scheduled allowance when Medically Necessary
Acupuncture <i>(Limit applies to In and Out of Network)</i>	50% coinsurance -10 visit maximum	50% coinsurance -10 visit maximum
Facility – Emergency Room	Covered in full \$200 penalty for non-emergency	Covered in full \$200 penalty for non-emergency
Freestanding Urgent Care Center	\$25 Co-Pay	Deductible/Coinsurance
Autism Applied Behavior Analysis <i>(Physician medical services only)</i>	Specialist Co-Pay	Deductible/Coinsurance
Autism Assistive Communication Devices (ACD)	Specialist Co-Pay	Deductible/Coinsurance

ADDITIONAL BENEFITS

EMPLOYEE MEMBER ASSISTANCE PROGRAM

Call ▷ 1-866-269-7357

Or Log On To:
<https://hmc.personaladvantage.com>
Code: LOCALONE

Free Services – 24/7

Whatever the Stress: Relationships/Family, Work, Alcohol/Drugs, Anxiety, Depression, Finances, Grief, Aging Parents, Legal

ALSO INCLUDES – Up to 5 FREE Counseling Sessions



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ADDITIONAL BENEFITS

VISION BENEFIT

DAVIS VISION
(800) 999-5431 or
www.davisvision.com

General Benefit: Up to \$150.00 maximum – including eyeglasses

ADULT - every 2 years

CHILD – every year

*Individual Plan covers member only

Safety Glasses: Annual benefit for those members who need them for work

**PRESCRIPTION
 DRUG BENEFIT**



Customer Service
1-800-681-6912

FOR SPECIALTY DRUGS
LOG ONTO www.Accredo.com
Or call 1-800-803-2523

** A LIST OF CORE THERAPY DRUGS
 CAN BE FOUND AT www.ufcwone.com.

**ORDER YOUR DIABETIC
 SUPPLIES (No Co-Pays)**
1-877-316-2460
Or ONLINE at
www.onesourcemg.com

CO-PAYMENT – WITH 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 \$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
20% (Min. \$15 – Max \$25)	25% (Min. \$30 – Max \$50)	50% (Min. \$50 – Max \$100)

90 Day Supply

GENERIC	BRAND	Non- PREFERRED BRAND
20% (Min. \$40 – Max \$70)	25% (Min. \$85 – Max \$125)	50% (Min/ 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



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<p align="center">DENTAL BENEFIT</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 align="center">The Loomis Company P.O. Box 7011 Wyomissing, PA 19610-6011 Or Visit their Website at www.loomisco.com</p> <p><i>For questions regarding your claim(s), please call the Health Care Fund Claims Service Unit at</i> 1-800-959-9497</p> <p>A LIST OF IN-NETWORK PROVIDERS CAN BE FOUND AT: www.ufcwone.org</p>	<p>Maximum Benefit: \$1,850 per Participant per year Preventative Care: Paid @ 100% of Fee Schedule All Other Services: Paid at 90% of Fee Schedule With 10% Co-Insurance paid by Member.</p> <p align="center"><i>Orthodontics - \$2,000 per lifetime maximum</i></p> <p>NOTE: Any charges incurred due to extraction of wisdom teeth will be applied to the annual maximum</p> <p align="center"><i>General Dentistry - Eligible upon 7th Contribution.</i></p> <p align="center"><i>Extensive Dentistry – Eligible upon 13th Contribution.</i></p>																		
<p align="center">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> <hr/> <p>NOTE: MEMBERS HIRED ON OR AFTER 1/1/2018</p> <p><i>Age 65 – 35% Reduction</i></p> <p><i>Age 70 – 50% Reduction</i></p> <p><i>Applies to both full-time and part-time employees.</i></p>	<table border="0"> <thead> <tr> <th align="center"><i>Full-Time:</i></th> <th align="center"><i>Part-Time:</i></th> </tr> </thead> <tbody> <tr> <td align="center">Less than 16yrs</td> <td align="center">Less than 16yrs</td> </tr> <tr> <td align="center">\$25,000</td> <td align="center">\$10,000</td> </tr> <tr> <td align="center">16-19yrs</td> <td align="center">16-19yrs</td> </tr> <tr> <td align="center">\$30,000</td> <td align="center">\$15,000</td> </tr> <tr> <td align="center">20-24yrs</td> <td align="center">20-24yrs</td> </tr> <tr> <td align="center">\$40,000</td> <td align="center">\$20,000</td> </tr> <tr> <td align="center">25yrs plus</td> <td align="center">25yrs plus</td> </tr> <tr> <td align="center">\$50,000</td> <td align="center">\$25,000</td> </tr> </tbody> </table>	<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
<i>Full-Time:</i>	<i>Part-Time:</i>																		
Less than 16yrs	Less than 16yrs																		
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\$40,000	\$20,000																		
25yrs plus	25yrs plus																		
\$50,000	\$25,000																		
<p align="center">Accidental Death</p>	<p align="center">Follows same schedule as above</p>																		
<p align="center">Dependent Life Insurance (Family Coverage)</p>	<p align="center">FT Coverage - Spouse - \$2,000 Child - \$2,000 PT Coverage - \$1,000 if purchasing Family Coverage</p>																		
<p align="center">Education/Scholarship</p>	<p align="center">Industry related classes paid up to \$400 \$1,000 average college scholarship (Eligibility rules applies)</p>																		



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Does this Coverage Provide Minimum Essential Coverage? Since your coverage under the Fund's Plan U 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 U 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 U is the equivalent of a Gold plan on the state Exchange.**

Helpful WEBSITE Links

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