UFCW Local One Benefit Funds

SUMMARY PLAN DESCRIPTION
PP0 Plan
EFFECTIVE: January 1, 2021

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DEPENDENT COVERAGE	**Coverage for Biological & Adopted Children:** Up to age 26 years. **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.	
PRE-CERTIFICATION **1-800-363-4658**	YES • 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 Center – APS. • Penalty of $500 or 50% whichever is less for **No Pre-Certification.**	
Excellus Blue Cross Blue Shield **MEDICAL INQUIRES**	**Dedicated Customer Care Line** **1-877-223-2993**	
COST SHARING EXPENSES	**PPO In-Network**	**PPO Out-of Network**
Deductible	$1,000 individual/$3,000 family	$2,000 individual/$6,000 family
Deductible Carry-Over Y/N (October, November and December Carryover)	Yes	Yes
Office Visit Co-Pay	$20, except where noted	Deductible/Coinsurance
Specialist Office Visit Co-Pay	$30, except where noted	Deductible/Coinsurance
MDLIVE (Telemedicine) –24/7 **TEXT** – EXCELLUS to 635483 **Or REGISTER/LOG IN AT:** *ExcellusBCBS.com/Member*	$15 Co-Payment ***24/7 Access to a Doctor***	
Coinsurance	20%, except where noted	40%, except where noted
Annual Out-of-Pocket Maximum (includes deductible, coinsurance and co-payment, excludes artificial insemination)	Medical: $4,000 individual/$12,000 family Prescription Drugs: $2,600 individual/$5,200 family	Medical: $8,000 individual/$24,000 family

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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
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 (*Limit applies to IN and OUT of Network)*	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

Hemodialysis	Deductible/Coinsurance	Deductible/Coinsurance
Home Care	$50 Deductible/20% Coinsurance – unlimited visits	$50 Deductible/25% Coinsurance – unlimited visits
PHYSICIAN SERVICES/OFFICE VISITS	**PPO In-Network**	**PPO Out-of Network**
Hospice Care **(Includes 5 bereavement counseling visits)**	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 **(mandated visits/immunizations full coverage, Including Gardasil (HPV)**	Covered in full	Covered in full
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 *Includes Gestational Diabetes Screenings, HPV Testing & HIV Testing and Counseling.*	Covered in Full	Deductible/Coinsurance
In-Hospital Physician Visits	Deductible/Coinsurance	Deductible/Coinsurance
Respiratory Therapy	Deductible/Coinsurance	Deductible/Coinsurance
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 *Flu Shots, FluMist, Hepatitis A,B, Tetanus, Diptheria, (TD) Measles, Mumps, Rubella (MMR), Varicella, Pneumococcal (polysaccharide) & Meningococcal Immunizations, H1N1, HPV (Gardisil-3 doses), Rotavirus (Rotateq), Zostavax*	Covered in Full	Covered in Full
Chiropractic Care (*Limit applies to IN and OUT of Network)*	Office Visit Co-Pay – 30 visits per year	Deductible/Coinsurance–30 visits per yr
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) ***(Precertification applies if over $200)***	Deductible/Coinsurance	Deductible/Coinsurance
External Prosthetics/Orthotics **(Foot orthotics excluded)**	Deductible/Coinsurance	Deductible/Coinsurance
Medical Supplies	Deductible/Coinsurance	Deductible/Coinsurance
Hearing Aids (*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.
Hearing Evaluations Diagnostic	Office Visit 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 (*Limit applies to IN and OUT of Network)*	50% coinsurance -10 visit maximum	50% coinsurance -10 visit maximum
Facility – Emergency Room	Covered in full $200 Penalty for non-emergency	Covered in full (100% of Allowance) $200 Penalty for non-emergency
Freestanding Urgent Care Center	$25 Co-Pay	Deductible/Coinsurance
Autism Applied Behavior Analysis (Physician medical services only)	Specialist Co-Pay	Deductible/Coinsurance

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Autism Assistive Communication Devices (ACD)	Specialist Co-Pay	Deductible/Coinsurance

ADDITIONAL BENEFITS

PRESCRIPTION DRUG BENEFIT

HealthSmart Rx Solutions

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.

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

Thirty (30) Day Supply from Retail Pharmacy

CO-PAYMENT

GENERIC	BRAND	Non-PREFERRED BRAND
20% (Min. $15 – Max $30)	30% (Min. $30 – Max $85)	50% (Min. $55 – Max None)

*****Exception - Core Therapy Drugs limited to $10 Co-Pay.***

Ninety (90) Day Supply from Mail Order OR Tops Markets & Parkway Drugs

GENERIC	BRAND	Non-PREFERRED BRAND
20% (Min. $40 – Max $100)	30% (Min. $85 – Max $200)	50% (Min $200 -Max None)

*****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

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

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ADDITIONAL BENEFITS

DENTAL BENEFIT

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:

The Loomis Company
P.O. Box 7011
Wyomissing, PA 19610-6011
Or Visit their Website at
www.loomisco.com

For questions regarding your claim(s), please call the Health Care Fund Claims Service Unit at
1-800-959-9497

A LIST OF IN-NETWORK PROVIDERS CAN BE FOUND AT:
www.ufcwone.org

Maximum Benefit: $750 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.

Orthodontics - $1,000 per lifetime maximum

NOTE: Any charges incurred due to extraction of wisdom teeth will be applied to the annual maximum

General Dentistry **- Eligible upon 7th Contribution.**

Extensive Dentistry **– Eligible upon 13th Contribution.**

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

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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.onesourcemg.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