



**SUMMARY PLAN DESCRIPTION**

**PPO Plan**

**EFFECTIVE: January 1, 2022**

**U**

<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><b>Deductible w/ Wellness Incentive</b></p>	<p>\$400 individual / \$1,200 family</p>	<p>\$800 individual / \$2,400 family</p>
<p><b>Deductible w/o Wellness Incentive</b></p>	<p>\$500 individual / \$1,500 family</p>	<p>\$800 individual / \$2,400 family</p>
<p><b>Deductible Carry-Over Y/N (October, November and December Carryover)</b></p>	<p>Yes</p>	<p>Yes</p>
<p><b>Office Visit Co-payment w/ Wellness Incentive</b></p>	<p>\$12, except where noted</p>	<p>Deductible/Coinsurance</p>
<p><b>Office Visit Co-payment w/o Wellness Incentive</b></p>	<p>\$15, except where noted</p>	<p>Deductible/Coinsurance</p>



**SUMMARY PLAN DESCRIPTION**

**PPO Plan**

**EFFECTIVE: January 1, 2022**

**U**

<b>COST SHARING EXPENSES</b>	<b>PPO In-Network</b>	<b>PPO Out-of Network</b>
<b>Specialist Office Visit w/ Wellness Incentive</b>	\$25 except where noted	Deductible/Coinsurance
<b>Specialist Office Visit w/o Wellness Incentive</b>	\$30 except where noted	Deductible/Coinsurance
<b>MDLIVE (Telemedicine) –24/7</b> TEXT – EXCELLUS to 635483 Or REGISTER/LOG IN AT: <a href="http://ExcellusBCBS.com/Member">ExcellusBCBS.com/Member</a>	<b>No Co-Pay</b>  <i>24/7 Access to a Doctor</i>	
<b>Coinsurance with and without Wellness Incentive</b>	20%, except where noted	40%, except where noted
<b>Annual Out-of-Pocket Maximum w/ Wellness Incentive</b>  (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
<b>Annual Out-of-Pocket Maximum w/o Wellness Incentive</b>  (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
<b>HOSPITAL INPATIENT SERVICES</b>	<b>PPO In-Network</b>	<b>PPO Out-of Network</b>
<b>Inpatient Hospital Services</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Maternity Care</b> (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
<b>Newborn Nursery Care</b>	Coinsurance	Deductible/Coinsurance
<b>Internal Prosthetics</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Skilled Nursing Facility</b> (Limit applies to IN and OUT of Network)	Deductible/Coinsurance (120 days per calendar year)	Deductible/Coinsurance (120 days per calendar year)
<b>Physical Rehabilitation</b> (Limit applies to IN and OUT of Network)	Covered in Full 60 days per calendar year	Deductible/Coinsurance 60 days per calendar year



**SUMMARY PLAN DESCRIPTION**

**PPO Plan**

**EFFECTIVE: January 1, 2022**

**U**

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
<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
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
<b>PHYSICIAN SERVICES/OFFICE VISITS</b>	<b>PPO In-Network</b>	<b>PPO Out-of Network</b>
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



**SUMMARY PLAN DESCRIPTION**

**PPO Plan**

**EFFECTIVE: January 1, 2022**

**U**

<b>Diagnostic GYN Visits</b>	Office Visit Co-Pay	Deductible/Coinsurance
<b>Diagnostic Office Visits</b>	Office Visit Co-Pay	Deductible/Coinsurance
<b>Routine GYN Visits including Pap Smear – NO AGE LIMIT One Exam Per Year</b>	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 Unlimited visits	Deductible/Coinsurance Unlimited visits
<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



**SUMMARY PLAN DESCRIPTION**

**PP0 Plan**

**EFFECTIVE: January 1, 2022**

**U**

<b>Durable Medical Equipment (DME)</b> <i>(Precertification applies if over \$200)</i>	Deductible/Coinsurance	Deductible/Coinsurance
<b>External Prosthetics/Orthotics</b> <i>(Foot orthotics excluded)</i>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Medical Supplies</b>	Deductible/Coinsurance	Deductible/Coinsurance
<b>Hearing Aids</b> <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.
<b>Hearing Evaluations Diagnostic</b>	Specialist 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> <i>(Limit applies to In and Out of Network)</i>	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> <i>(Physician medical services only)</i>	Specialist Co-Pay	Deductible/Coinsurance
<b>Autism Assistive Communication Devices (ACD)</b>	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



**SUMMARY PLAN DESCRIPTION**

**PP0 Plan**

**EFFECTIVE: January 1, 2022**

**U**

**ADDITIONAL BENEFITS**

**VISION BENEFIT**

**DAVIS VISION**  
**(800) 999-5431** or  
[www.davisvision.com](http://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](http://www.Accredo.com)  
 Or call 1-800-803-2523

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

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



**SUMMARY PLAN DESCRIPTION**

**PPO Plan**

**EFFECTIVE: January 1, 2022**

**U**

<p align="center"><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 align="center"><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 align="center"><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 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"><b>LIFE INSURANCE</b></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><b>NOTE: MEMBERS HIRED ON OR AFTER 1/1/2018</b></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"><b>16-19yrs</b></td> <td align="center"><b>16-19yrs</b></td> </tr> <tr> <td align="center">\$30,000</td> <td align="center">\$15,000</td> </tr> <tr> <td align="center"><b>20-24yrs</b></td> <td align="center"><b>20-24yrs</b></td> </tr> <tr> <td align="center">\$40,000</td> <td align="center">\$20,000</td> </tr> <tr> <td align="center"><b>25yrs plus</b></td> <td align="center"><b>25yrs plus</b></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	<b>16-19yrs</b>	<b>16-19yrs</b>	\$30,000	\$15,000	<b>20-24yrs</b>	<b>20-24yrs</b>	\$40,000	\$20,000	<b>25yrs plus</b>	<b>25yrs plus</b>	\$50,000	\$25,000
<i>Full-Time:</i>	<i>Part-Time:</i>																		
Less than 16yrs	Less than 16yrs																		
\$25,000	\$10,000																		
<b>16-19yrs</b>	<b>16-19yrs</b>																		
\$30,000	\$15,000																		
<b>20-24yrs</b>	<b>20-24yrs</b>																		
\$40,000	\$20,000																		
<b>25yrs plus</b>	<b>25yrs plus</b>																		
\$50,000	\$25,000																		
<p align="center"><b>Accidental Death</b></p>	<p align="center">Follows same schedule as above</p>																		
<p align="center"><b>Dependent Life Insurance (Family Coverage)</b></p>	<p align="center">FT Coverage - Spouse - \$2,000    Child - \$2,000            PT Coverage - \$1,000 if purchasing Family Coverage</p>																		
<p align="center"><b>Education/Scholarship</b></p>	<p align="center">Industry related classes paid up to \$400            \$1,000 average college scholarship            (Eligibility rules applies)</p>																		



## SUMMARY PLAN DESCRIPTION

**PPO Plan**

**EFFECTIVE: January 1, 2019**

**U**

**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 2022.

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

### 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