UFCW Local One Benefit Funds

SUMMARY PLAN DESCRIPTION
PP0 Plan
EFFECTIVE: January 1, 2025

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

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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 ***24/7 Access to a Doctor***	
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)**	Medical: $2,000 individual / $6,000 family Prescription Drugs: $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)**	Medical: $2,500 individual / $7,500 family Prescription Drugs: $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

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 Surgical centers/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 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 (mandated visits/immunizations full coverage, Including Gardasil (HPV)	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
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 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 *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 calendar year	Deductible/Coinsurance – 30 visits per calendar year
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	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 **(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 $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
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 $155.00 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.

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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DENTAL BENEFIT **ALL Dental Claims should be submitted to Delta Dental for processing and Payment. Claims can be submitted by your dental provider or by you directly to:** **Delta Dental** **P.O. Box 2105** **Mechanicsburg, PA 17055** **Or Visit their Website at:** **www.deltadentalins.com** *For questions regarding your claim(s), please call Delta Dental PPO at:* ***1-800-932-0783*** **A LIST OF IN-NETWORK PROVIDERS CAN BE FOUND AT:** **www.deltadentalins.com**	**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. *Orthodontics - $2,000 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.**
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.** **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.*	***Full-Time:*** / ***Part-Time:*** **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
Accidental Death	Follows same schedule as above
Dependent Life Insurance (Family Coverage)	FT Coverage - Spouse - $2,000 Child - $2,000 PT Coverage - $1,000 if purchasing Family Coverage
Education/Scholarship	Industry related classes paid up to $400 $1,000 average college scholarship (Eligibility rules applies)

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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 2023.

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
LucyRX (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
Delta Dental PPO	-	www.deltadentalins.com

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
LucyRX (Prescription Mail Order)	-	1-800-681-6912
Accredo (Specialty Drugs)	-	1-800-803-2523
Delta Dental PPO	-	1-800-932-0783