UFCW Local One Benefit Funds

SUMMARY PLAN DESCRIPTION
PP0 Plan
EFFECTIVE: June 1, 2025

Q

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*	No Co-Pay ***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

Unified LaborRX
Customer Service
1-800-654-2111

FOR SPECIALTY DRUGS LOG ONTO
www.primetherapeutics.com
Or call 1-866-364-2673

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 $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

ADDITIONAL BENEFITS

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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: $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 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 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
Unified LaborRX	-	www.unifiedlaborrx.com
Excellus Blue Cross Blue Shield	-	www.excellusbcbs.com/UFCWONE
Davis Vision	-	www.davisvision.com
Specialty Drugs (Prime Therapeutics)	-	www.primetherapeutics.com/patientforms
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.deltaldentalins.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
Unified LaborRX (Prescription Mail Order)	-	1-844-654-2111
Prime Therapeutics (Specialty Drugs)	-	1-866-554-2673
Delta Dental PPO	-	1-800-932-0783