UFCW Local One Benefit Funds

SUMMARY PLAN DESCRIPTION
PP0 Plan
EFFECTIVE: June 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	$300 individual / $900 family	$400 individual / $1,200 family
Deductible w/o Wellness Incentive	$400 individual / $1,200 family	$400 individual / $1,200 family
Deductible Carry-Over Y/N (October, November and December Carryover)	Yes	Yes
Office Visit Co-payment w/ Wellness Incentive	$10, except where noted	Deductible/Coinsurance
Office Visit Co-Payment w/o Wellness Incentive	$12, except where noted	Deductible/Coinsurance
Specialist Office Visit w/ Wellness Incentive	$20 except where noted	Deductible/Coinsurance
Specialist Office Visit Co-Payment w/o Wellness Incentive	$25, 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	30%, except where noted
Annual Out-of-Pocket Maximum w/ Wellness Incentive **(includes deductible, coinsurance and co-payment, excludes artificial insemination)**	Medical: $1,500 individual / $4,500 family Pharmacy: $2,600 individual / $5,700 family	$2,000 individual / $6,000 family
Annual Out-of-Pocket Maximum w/o Wellness Incentive **(includes deductible, coinsurance and co-payment, excludes artificial insemination)**	Medical: $2,000 individual / $6,000 family Pharmacy: $2,600 individual / $5,700 family	$2,000 individual / $6,000 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 Surgery 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 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
Home Care	$50 Deductible/20% Coinsurance – unlimited visits	$50 Deductible/25% Coinsurance – unlimited visits
Hemodialysis	Deductible/Coinsurance	Deductible/Coinsurance
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
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	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 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 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 $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		

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R

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
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*
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.**

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R

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

CO-PAYMENT – WITH Wellness Incentive

30 Day Supply

GENERIC	BRAND	Non-PREFERRED BRAND
10% (Min. $15 – Max $25)	20% (Min. $30 – Max $50)	50% (Min. $50 – Max $100)

90 Day Supply

GENERIC	BRAND	Non-PREFERRED BRAND
10% (Min. $40 – Max $70)	20% (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
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 $15 Co-Pay*
NOTE: *Non-preferred brand drugs (drugs that have a generic available)

Generic Oral Contraceptives: No Co-Pay with prescription

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

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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)

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

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.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
Unified LaborRX (Prescription Mail Order)	-	1-844-654-2111
Prime Therapeutics (Specialty Drugs)	-	1-866-554-2673
Delta Dental PPO	-	1-800-932-0783