UFCW LOCAL 655
WELFARE FUND
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Schedule of Benefits
Plan C

Your Plan of Benefits – **Plan C (hired on or before December 1, 2010)**. Unit 1 includes medical, prescription drug card, vision, dental, weekly disability, life insurance and accidental death and dismemberment (AD&D) benefits. Dependents and Unit 2 Employees should refer to the Rolling Eligibility Form and to the description of the specific benefits in this Schedule of Benefits to determine whether they are covered by the Plan and whether they are eligible for specific benefits. **Employees hired on or after December 1, 2010 will qualify for Plan C benefits based on working the required hours. After 72 months of employment, employees are eligible to elect Plan B benefits during that qualifying years Annual Open Enrollment period, with the election commencing the Employees hired on or after December 1, 2010 are not eligible to elect plan A. Employees hired on or after January 1, 2017 are not eligible to elect Plan A or Plan B.**

Medical Benefits

Benefit and Payment Provisions	In-Network	Out-of-Network
Calendar Year Deductible	$550 per person; $1,650 per family.	$700 per person; $2,100 per family.
Calendar Year Medical Out-of-Pocket Maximum	$2,500 per person; $6,250 per family. Deductible included.	$5,000 per person; $12,500 per family. Deductible included.
Calendar Year Medical Copayment Out-of-Pocket Maximum	$1,600 per person; $3,200 per family.	Unlimited.
Calendar Year Rx Out-of-Pocket Maximum	$3,000 per person; $5,000 per family.	Unlimited.
In-Office Physician Care		
Office visit fee for illness or injury	Family practice physician, internist, pediatrician, or OB/GYN: **You pay $15 copay per visit.** **Specialist: You pay $20 copay per visit.** **Note: copay counts toward medical out-of-pocket copay maximum only.**	Plan pays 60% of allowable charge after deductible.
Pre- and post-maternity care (only employee/spouse covered)	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible.
X-ray and lab (outpatient)	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible.
Emergency Room / Urgent Care Services		
Emergency room charge for emergency services, as defined in the SPD	You pay $200 copay and no deductible, then Plan pays 70% (copay is waived if admitted from ER).	You pay $200 copay and no deductible, then Plan pays 60%. Plan pays In-Network percentage in the event of an emergency.
Urgent care facility	You pay $50 copay and no deductible, then Plan pays 70%.	You pay $50 copay and no deductible, then Plan pays 60% of allowable charge.
Ambulance service	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible. Plan pays In-Network percentage in the event of an emergency.

Medical Benefits

Hospital In-Patient

Benefit and Payment Provisions	In-Network	Out-of-Network
Hospital care, includes emergency room physician, radiologist, anesthesiologist, and pathologist care	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible.

Transplant Benefits

Organ/tissue transplant benefit maximum: $250,000 combined aggregate maximum regardless of transplant performed; benefit maximum starts 5 days prior to date of transplant and ends 18 months after the transplant.

Organ/tissue transplant benefits	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible.

Outpatient Surgery

Special note: Out-of-Network outpatient surgical centers are not covered by the Fund.

Surgery and related services (on same day)	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible, when services are rendered in an outpatient hospital facility only.
Outpatient Surgical Center	Plan pays 70% after deductible.	Not covered.

Outpatient Care

Diagnostic tests and X-rays Radiation therapy Dialysis treatment Cardiac and pulmonary rehabilitation Chemotherapy and infusion	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible.
MRI, CT, and PET scans performed by an Absolute Solutions network provider Call 800.321.5040 to begin the new referral process.	Plan pays 100% -no copay or deductible.	Out-of-Network benefits are not offered when using an Absolute Solutions network provider.
Home care, includes home respiratory, infusion therapy, and physical therapy Limited to 40 visits per 12-month period.	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible.
Skilled nursing facility care Limited to 60 days per episode of treatment.	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible.
Hospice care In-patient or Home Patient must have life expectancy of less than 6 months to be eligible.	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible.
Durable medical equipment, prosthetics and orthotics are limited to $1,000 maximum per piece of equipment, per date of service; wigs and prosthesis are limited to $150 lifetime maximum per person.	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible.
Weight loss programs Weight loss benefits payable up to $1,500 per lifetime maximum per person, including prescription drugs.	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible.

Medical Benefits (continued)

Physical, Speech and Occupational Therapy limit maximum: 40 combined visits per calendar year		
Physical, speech, and occupational therapy (preventive and maintenance care not covered)	You pay $20 copay per visit, then Plan pays 70%; no deductible.	You pay $20 copay per visit, then Plan pays 60% of allowable charge; no deductible.
Chiropractic Services — limit maximum: 20 visits per calendar year		
Chiropractic manipulations and other covered related services.	You pay $20 copay per visit, then Plan pays 70%; no deductible.	You pay $20 copay per visit, then Plan pays 60% of allowable charge; no deductible.
X-ray & lab prescribed in connection with chiropractic care	Plan pays 70% after deductible, up to one set of x-rays and one set of lab work per calendar year.	Plan pays 60% of allowable charge after deductible, up to one set of x-rays and one set of lab work per calendar year.
Mental Health and Substance Use Disorders Benefit		
MAP Counseling Sessions	Plan pays 100% of approved sessions.	Not covered.
Office Visit with Mental Health/Substance Abuse Provider	$15 copayment per visit.	Plan pays 60% of allowable charge after deductible.
In-Patient Services	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible.
Lab Services/Drug Screening	Plan pays 70% after deductible.	Plan pays 60% of allowable charge after deductible. **Please note: Additional documentation required to validate medical necessity.**
Member Assistance Program (MAP)		
24/7 Crisis Counseling	H&H Health Associates is here to help with counseling, resources, guidance and support.	
Short -Term Counseling	100%-No Copay or deductible and confidential.	
Child Care Resources	www.hhhealthassociates.com HEALTH ASSOCIATES® www.hhhealthassociates.com	
Elder Care Resources	Scan QR Code to access your Mental Health Benefits.	
Legal Assistance		
Work/Life Resources		
Online Resources		
Financial Assistance		

Preventative Care		
Benefit and Payment Provisions	**In-Network**	**Out-of-Network**
Routine Physical (1 per calendar year) Gynecological Exam (1 per calendar year) To avoid any possible Office Visit charges for Preventive Services you receive during the calendar year, you should have all Preventive Services performed during your Routine Physical or Gynecological Exam.	100% - no copay or deductible.	Plan pays 60% of allowable charge after deductible.
Well Child Care visits as provided in the American Academy of Pediatrics Bright Futures Guidelines.		
Preventive Care Services as recommended with an A or B rating by the United States Preventive Services Task Force and preventive care and screenings for women as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.		
Seasonal Flu Shot Vaccination		
Hearing exams (1 per calendar year)	Plan pays 70%; 100% for hearing screenings for children; no deductible.	
DC guidelines	Plan pays 100%; no deductible.	
Pap smear (1 per calendar year)	Plan pays 100%; no deductible.	
Routine mammograms (1 per calendar year beginning at age 40) (covered as outlined by American Cancer Society.)	Plan pays 100%; no deductible.	
Family planning Infertility lab work Infertility treatment Benefits payable up to $10,000 lifetime maximum.	Plan pays 50%; no deductible.	
Contraceptives: At least one method in each of the 18 categories of contraceptives described in the Women's Preventative Services Section of the SPD will be covered at no cost to the Participant; oral contraceptives are covered under the Prescription Drug Card Program.	Plan pays 100%; no copay or deductible.	

Prescription Drug Card Program		
Annual deductible	$200 deductible.	Unlimited.
Calendar Year Rx Out-of-Pocket Maximum	$3,000 per person; $5,000 per family.	
Type Of Medication	**Participating Network Retail Pharmacy (up to 30-day supply)**	
Generic Drugs	You pay 15% or $10 copay (whichever is greater); with $50 maximum copay.	
Single-Source Brand Name Drugs (no generic available)	You pay 25% or $20 copay (whichever is greater); with $100 maximum copay.	
Multi-Source Brand Name Drugs	You pay 25% of generic cost or $20 copay (whichever is greater), plus the difference between the brand name and generic price.	
Generic and Single-Source Contraceptives	Plan pays 100%; no copay or deductible.	
Type Of Medication	**Mail Order Program** (up to 90-day supply)**	
Generic Drugs	You pay 10% or $20 copay (whichever is greater); with $150 maximum copay for 90-day supply.	
Single-Source Brand Name Drugs (no generic available)	You pay 25% or $40 copay (whichever is greater); with $300 maximum copay for 90-day supply.	
Multi-Source Brand Name Drugs	You pay 25% of generic cost or $40 copay, plus the difference between the brand name and generic price.	
Generic and Single-Source Contraceptives	Plan pays 100%; no copay or deductible.	

****You may also fill your maintenance prescriptions (up to 90-day supply) at all Schnucks, Dierbergs, and Kroger stores that have pharmacies. You must have filled at least one 30-day supply of the prescription at retail before you are eligible to fill the 90-day supply. The mail order co-pays shown above apply.**

Dental Benefits

Only Unit 1 employees and dependents are eligible for dental benefits

To find an In-Network dental provider in your area, log into www.655hw.org. You will go to benefits, dental provider directory and click on "Find Dentist." Our dental plan is Delta Dental of Missouri effective 1-1-2023. The benefits of using an in-network provider, your out-of-pocket costs will be lower than using an Out-of-network provider since these providers have agreed to offer their services with discounted rates.

Service	Benefits Payable
Calendar year maximum payable for Coverages A, B and C combined	$3,000 per person, except that this limit does not apply to Coverage A for dependent children under age 19.
Coverage A: routine exams, prophylaxis, fluoride treatment and x-rays– each service allowed twice per calendar year regardless of the amount of time between services.	Plan covers 100% of allowable charge. Dependent children under age 19 are limited to two exams and one set of x-rays per calendar year with no annual dollar limit.
Coverage B: restorative, basic dental care and periodontics, (veneers must be preauthorized.)	Plan covers 80% of allowable charge.
Coverage C: crowns, bridges and dentures (partials and complete), but replacements are covered if not less than 5 years after the crown, bridge or denture was last installed.	Plan covers 50% of allowable charge.
Orthodontia for children through age 18 only (must be banded prior to 19th birthday.)	Plan covers 80% of allowable charge up to $2,000 lifetime maximum.

Vision Care Benefits

Call VSP Vision Care at 1-800-877-7195 or visit their web site at www.vsp.com whenever you need to locate a vision care provider in your area. When you call to make an appointment, tell the doctor you are a VSP member. Your ID card will not be needed.

Vision Care (through VSP Choice Providers Only)	Benefits Payable	Frequency
Well Vision Exam (eye exam related to illness or injury covered under medical benefits)	Plan covers 100% after you pay a $10 copay.	Every calendar year
Prescription lenses: • Single vision; • Lined bifocal; • Lined trifocal; and • Polycarbonate lenses for dependent children up to age 18	Plan covers 100% after you pay a $20 copay.	Every calendar year
Allowance for frames	Plan covers a maximum of $175; you receive 20% off any amount over the maximum.	Every other calendar year
Allowance for contact lenses and contact lens exam (fitting and evaluation.)	Plan covers a maximum of $175.	Every calendar year
Non-VSP Service Providers		
No benefits available.		

Hearing Benefits

Call Tru Hearing at1-844-259-7632 or visit their web site at www.TruHearing.com whenever you need to locate a hearing provider in your area.

Hearing Aid Benefit	Covered only if they are recommended by a network provider. Contact Fund Office for instructions on claims submission. The plan allows up to a maximum of $500 per ear every 5 years.

Weekly Disability Income Benefits

Level Of Coverage	Unit 1	Unit 2
Eligibility begins on	The 1st day of an accident or the 4th day of an illness.	No coverage.
Percentage of payment	70% of the average base pay you received during the four weeks immediately preceding the disability; with a maximum of $600 per week.	N/A
Maximum period of pay	13 weeks	N/A
Reinstatement of weekly disability benefit	Benefits are restored when you return to work and work your average weekly hours (minimum of 25-32 hours per week based on your date of hire for Unit 1 eligibility qualification).	N/A

Life Insurance Benefit

In the event of your death	Hire date at least one year but less than 10 years $10,000 at least 10 years but less than 15 years $15,000 at least 15 years but less than 20 years $20,000 20+ years $25,000	Hire date at least one year but less than 10 years $2,000 at least 10 years but less than 15 years $5,000 at least 15 years but less than 20 years $10,000 20+ years $15,000

Accidental Dealth and Dismemberment Benefit

In the event your death is a result of an accident your beneficiary will receive the following in addition to the Life Insurance Benefit	Hire date at least one year but less than 10 years $10,000 at least 10 years but less than 15 years $15,000 at least 15 years but less than 20 years $20,000 20+ years $25,000	Hire date at least one year but less than 10 years $2,000 at least 10 years but less than 15 years $5,000 at least 15 years but less than 20 years $10,000 20+ years $15,000
Felonious Assault	Hire date at least one year but less than 10 years $1,000 at least 10 years but less than 15 years $1,500 at least 15 years but less than 20 years $2,000 20+ years $2,500	Hire date at least one year but less than 10 years $200 at least 10 years but less than 15 years $500 at least 15 years but less than 20 years $1,000 20+ years $1,500
Uniplegia	Hire date at least one year but less than 10 years $2,500 at least 10 years but less than 15 years $3,750 at least 15 years but less than 20 years $5,000 20+ years $6,250	Hire date at least one year but less than 10 years $500 at least 10 years but less than 15 years $1,250 at least 15 years but less than 20 years $2,500 20+ years $3,750
Hemiplegia, or loss of any one of: hands, feet, sight of an eye, speech, or hearing	Hire date at least one year but less than 10 years $5,000 at least 10 years but less than 15 years $7,500 at least 15 years but less than 20 years $10,000 20+ years $12,500	Hire date at least one year but less than 10 years $1,000 at least 10 years but less than 15 years $2,500 at least 15 years but less than 20 years $5,000 20+ years $7,500
Paraplegia	Hire date at least one year but less than 10 years $7,500 at least 10 years but less than 15 years $11,250 at least 15 years but less than 20 years $15,000 20+ years $18,750	Hire date at least one year but less than 10 years $1,500 at least 10 years but less than 15 years $3,750 at least 15 years but less than 20 years $7,500 20+ years $11,250
Quadriplegia, or loss of any two of: hands, feet, sight of an eye, speech, or hearing	Hire date at least one year but less than 10 years $10,000 at least 10 years but less than 15 years $15,000 at least 15 years but less than 20 years $20,000 20+ years $25,000	Hire date at least one year but less than 10 years $2,000 at least 10 years but less than 15 years $5,000 at least 15 years but less than 20 years $10,000 20+ years $15,000

Accelerated Benefit

In the event you have a terminal illness with a life expectancy of 12 months or less	Hire date at least one year but less than 10 years $5,000 at least 10 years but less than 15 years $7,500 at least 15 years but less than 20 years $10,000 20+ years $12,500	Hire date at least one year but less than 10 years $1,000 at least 10 years but less than 15 years $2,500 at least 15 years but less than 20 years $5,000 20+ years $7,500

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Participant Portal

The Participant Portal has been designed to allow participants to access information regarding their eligibility and benefits at their convenience!

WWW.655HW.ORG

Lets Register!

To register, scan QR Code or visit www.655hw.org, click on **Participant Portal Login** link and next click **Register a New Account** button.

Once registration is complete, an **activation code** will be sent to the email address that you supplied during registration.

After the activation code is recieved, participants will need to go to the log in page and click **Activate my Account** and login (one time) with their username, password and activation code.

Now you are all set to login with your username and password to begin exploring your portal!

Participants may view the following:

- Eligibility
- Enrollment Election
- Plan Selection
- Current Premium Share Rate
- Work History
- Life Insurance Benefit
- Beneficiary Information
- Claims
- General Information
- Upload Important Documents

If you need further assistance, please contact the Fund Office at 314.835.2700 or toll free at 866.565.2700.