SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE PLATINUM PLUS PLAN

As of January 1, 2022

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator by phone or in writing at So. California Drug Benefit Fund, 2220 Hyperion Avenue, Los Angeles, CA 90027, (323) 666-8910. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2022

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CONTACT INFORMATION		
Trust Fund Office	877-999-8329	www.ufcwdrugtrust.org
Anthem Blue Cross Prudent Buyer	800-227-3641	www.anthem.com/ca/home.html
BlueCard	800-810-2583 (800-810-BLUE)	www.bcbs.com
Delta Dental	800-765-6003	www.deltadentalins.com
HMC HealthWorks	866-268-2510	https://hmc.personaladvantage.com (Access Code: SCDBF)
Kaiser	800-464-4000	www.kp.org
OptumRx	800-788-7871	www.optumrx.com
Podiatry Plan, Inc.	800-367-7762	www.podiatryplan.com
United Concordia	800-937-6432	www.unitedconcordia.com
UnitedHealthcare (UHC)	800-624-8822	www.MyUHC.com

SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2022

ELIGIBILITY RULES	
ESTABLISHING ELIGIBILITY & COVERAGE COMMENCEMENT	
All Employees	If you work an average of 23 or more hours per week ("Qualifying Hours") for 3 consecutive months, you and your Dependents will become eligible for all benefits, except orthodontic benefits, on the first day of the month after 2 skip months. For example, if you work Qualifying Hours in January, February, and March, you and your Dependents will be eligible for benefits, except orthodontic benefits, on June 1. Newly eligible participants, except for Kaiser Employees, are required to enroll in the Indemnity Medical Plan and will be eligible to enroll in an HMO plan on the 2nd annual open enrollment after their date of hire. Orthodontic coverage will be available to you and your Dependents after you have 9 consecutive months of eligibility in the Platinum Plus Plan.
Maintaining Eligibility	Once you become eligible, you must continue to work the Qualifying Hours during each month to maintain eligibility for yourself and your eligible Dependents.
WORKING SPOUSE RULE AND COORDINATION OF BENEFITS	
Working Spouse Rule (applies to spouses and Domestic Partners)	For married Employees and Employees with Domestic Partners (the use of the term "spouse" in this section includes Domestic Partners): If your spouse's employer offers health care coverage, your spouse must enroll in that employer's coverage that is comparable to your coverage under this Fund, even if your spouse is required to contribute toward the cost of that coverage. If your spouse's employer does not offer coverage that is comparable to your coverage from the Fund, your spouse must enroll in the best coverage available through his or her employer. If your spouse is eligible for medical, prescription drug, dental, and/or vision benefits through his or her employer but fails to enroll, this Plan will pay only 40% of its normal benefits (i.e., this Plan will reduce its payment amount by 60%) under the Indemnity Medical Plan, Prescription Drug Plan, and/or Indemnity Dental Plan. This rule does not apply if both spouses are eligible for coverage as Employees of contributing Employers and one spouse has elected coverage for "Employee plus spouse or Domestic Partner". Please contact the Fund Office for more information.

DEATH BENEFITS	
Employee	Greater of $15,000 or the amount of salary received during the most recent 12 months.
Dependent	$2,000

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
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MEDICAL PLAN OPTIONS	
DEFINITIONS	
Allowed Amount	The Allowed Amount is the allowance that the Fund has determined is an appropriate payment for the Medically Necessary service(s) rendered to the participant in the provider's geographic area. Where the provider's charge is less than the Fund's allowance for the service(s) provided, the Allowed Amount is the provider's billed amount. The Board of Trustees, or its designee, has discretion to determine the Allowed Amount.
Contract Rates	The amount that the PPO Provider (Prudent Buyer Network, the BlueCard Program, HMC) has agreed by contract to accept for services provided.
HOW THE PLAN WORKS – INDEMNITY MEDICAL PLAN	
Provider Network	If you live in California, your preferred provider network ("PPO") is the **Anthem Blue Cross of California Prudent Buyer network**. If you or your Dependents live outside of California, or if you are traveling outside California, your PPO network of hospitals and doctors is the **National BlueCard network**. The BlueCard network is available in all 50 states. You are strongly encouraged to use a PPO provider. The Plan pays a higher level of benefits when you use a PPO physician or hospital. You may choose to use hospitals and physicians that do not belong to the PPO networks. However, the Plan pays a lower level of benefits for non-PPO providers, and you will have higher out-of-pocket expenses. To find a PPO provider nearest you, call Anthem Blue Cross Prudent Buyer at 800-227-3641 or BlueCard Access at 800-810-BLUE. When Preauthorization or Utilization Review is required, your doctor or hospital must contact Prudent Buyer/BlueCard at 800-274-7767. PPO hospitals will do this automatically. You should confirm that your other providers, including non-PPO hospitals, have done this. For mental health and substance abuse treatments, your PPO is the **HMC HealthWorks (HMC) network**. Coverage is administered by HMC. Before receiving treatments, contact HMC at 866-268- 2510. Preauthorization by HMC is required for all inpatient treatments (except emergency hospitalization), intensive outpatient programs, partial hospitalization, ECT, psychological testing, and neuropsychological testing.
How the plan works – Services by PPO Providers	For most office visits, you must pay a $10 copay per visit. Then the Plan pays 100% of Contract Rates. When you use a PPO provider for preventive and wellness services, the Plan will pay 100% of Contract Rates for all of the preventive care and immunization services listed in the Plan's current Preventive Care Guidelines (available from the Fund Office). There is no copayment as long as the preventive services are received from PPO providers.
How the plan works – Services by non-PPO Providers	For most services, the Plan pays both Basic and Major Medical benefits. Basic Medical Benefits are paid first. After Basic Medical benefits have been exhausted, you must satisfy the required Calendar Year Deductible ("Deductible"), then the Plan pays a percentage of the remaining Allowed Amount as a Major Medical benefit. For some services and supplies, specific dollar limits are imposed. You are responsible for any remaining balance after the allowed Basic and Major Medical benefits are paid.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2022

MEDICAL PLAN OPTIONS	
HOW THE PLAN WORKS – KAISER	
Provider Network	You must use **Kaiser** providers. Services rendered by non-Kaiser providers are not covered. If an emergency occurs outside of Kaiser's service areas, emergency procedures and benefits apply.
How the plan works	Hospital and professional services are generally provided at no charge if received at Kaiser facilities and provided by Kaiser providers. Refer to each benefit shown in the charts below for exceptions. See Kaiser's Evidence of Coverage (EOC) for further details.
HOW THE PLAN WORKS – UNITEDHEALTHCARE	
Provider Network	You must use UHC providers in the **SignatureValue Advantage (SVA)** network. Services rendered by a provider who is not in the SVA network are not covered, except for Emergency Services. **For mental health and substance abuse treatments, HMC HealthWorks (HMC) is your preferred provider network**. Coverage is administered by HMC. Before receiving treatment, contact HMC at 866-268- 2510. All services and treatments must be provided by HMC providers. Services rendered by a non-HMC provider are not covered, except for Emergency Services.
How the plan works	Hospital and professional services are generally provided at no charge if received at HMO contracted facilities and provided by HMO providers. Refer to each benefit shown in the charts below for exceptions. Preauthorization by **HMC** is required for all inpatient **mental health and substance abuse** treatments (except emergency hospitalization), intensive outpatient programs, partial hospitalization, ECT, psychological testing, and neuropsychological testing. See UHC's Evidence of Coverage (EOC) for further details.

MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
CALENDAR YEAR DEDUCTIBLE, ANNUAL/LIFETIME MAXIMUM, AND PREAUTHORIZATION and UTILIZATION REVIEW				
Calendar Year Deductible ("Deductible")	None	$50 per person per calendar year before Major Medical pays.	Not applicable	Not applicable

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
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MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
Annual/Lifetime Maximum	None	None	None	None
Preauthorization and Utilization Review	When Preauthorization or Utilization Review is required, your doctor or hospital must contact PrudentBuyer/BlueCard. PPO providers will do this automatically. You should confirm that your other providers, including non-PPO hospitals, have done this. To obtain preauthorization, call 800-274-7767 (in California) or 800-810-BLUE (outside California).		See Kaiser's Evidence of Coverage	See UHC's Evidence of Coverage
HOSPITAL BENEFITS				
Hospital Inpatient Services (including Room and Board and Ancillary Services)	Plan pays 100% of Contract Rates, up to 120 days per disability, including ICU and childbirth. After 120 days, Plan pays 80% of Contract Rates. Prudent Buyer/BlueCard providers are responsible for obtaining all Preauthorization and Utilization Review.	Plan pays 50% of the Allowed Amount, up to 120 days per disability, including ICU only (excludes childbirth). After 120 days, Plan pays 80% of the Allowed Amount. Prudent Buyer/BlueCard must Preauthorize all hospital admissions, except for childbirth or emergency hospitalizations. You must notify Anthem within 72 hours of an emergency admission. Call 800-274-7767 (in California) or 800-810-BLUE (outside California) for Preauthorization. Benefits will be reduced if you fail to obtain required Preauthorization. Unauthorized days are not covered.	100% covered	100% covered

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MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
Hospital Outpatient Facility Charges	Plan pays 100% of Contract Rates	Plan pays 85% of the Allowed Amount	100% covered	100% covered
Skilled Nursing Facility	Maximum benefit of 42.5% of the semiprivate room rate of the previous hospital stay, for up to 2 times the unused number of allowed days per disability. The number of allowed days is 120 days minus the number of days spent in the hospital. Patient must be transferred into the Skilled Nursing Facility within 14 days of acute care hospital stay lasting at least 3 days. Must be approved by Prudent Buyer/BlueCard.		As prescribed at designated facilities. 100% covered, limited to 100 days per benefit period.	As prescribed at designated facilities. 100% covered, limited to 100 days per calendar year from the first treatment per disability.
Emergency Room (Facility only, Physician charges are payable under Physician Hospital Visits)	Plan pays 100% of Contract Rates	For accident, Plan pays 85% of the Allowed Amount. For illness, Plan pays 68% of the Allowed Amount.	100% covered	$35 copay, waived if admitted as inpatient. Reasonable charges for emergency services received outside UHC service areas are covered subject to copayments.
	Determination of PPO versus non-PPO will be made based on the status of the hospital.			
Physician Hospital Visits	Plan pays 100% of Contract Rates	Basic Medical pays up to $25.50 per day. Major Medical pays 80% of the remaining Allowed Amount after Deductible.	100% covered	100% covered
Outpatient Surgical Centers	Plan pays 100% of Contract Rates	Plan pays a maximum of $350 per operation. You are responsible for any charges that exceed $350 and these out-of-pocket charges do not count toward the Deductible.	100% covered	100% covered
	Must be Preauthorized by Prudent Buyer/BlueCard			
Ambulance	Plan pays 100% of Contract Rates/Allowed Amount		100% covered	100% covered

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MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
PROFESSIONAL SERVICES				
Office Visits	$10 copay per visit	Basic Medical pays up to $25.50 per visit, up to a maximum of $300 per calendar year. Benefits begin on the 1st visit for each accident and on the 2nd visit for each illness. After Basic Medical and Deductible have been satisfied, Major Medical pays 80% of the remaining Allowed Amount.	100% covered	100% covered
Telehealth Visits	$0 copay through Anthem Health Online	Not available	100% covered	100% covered
Preventive Care Services	Plan pays 100% of Contract Rates. No copay is required.	After the Deductible, Plan pays 85% of the Allowed Amount	100% covered	100% covered
	Coverage is provided for the services, screenings, and exams listed, and subject to the frequency described, in the Fund's Preventive Care Guidelines. Breast pumps must be purchased and obtained through a PPO Durable Medical Equipment vendor, otherwise there is no coverage.			
Specialist Office Visits	$10 copay per visit	Basic Medical pays up to $60 per visit for each accident or illness when referred by attending physician. No Major Medical is payable.	100% covered	100% covered
Surgeon, Assistant Surgeon	Plan pays 100% of Contract Rates	Basic Medical benefits are paid according to a schedule of charges. Excess charges, after	100% covered	100% covered

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
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MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
		Basic Medical and Deductible, are covered under Major Medical at 80% of the Allowed Amount.		
Anesthesiologist	Plan pays 100% of Contract Rates	If provided in a hospital or outpatient surgical facility, Plan pays 85% of the Allowed Amount. If provided in a physician's office, Basic Medical pays $21.25 per visit and no Major Medical is payable.	100% covered	100% covered
Speech Therapy Visits	$10 copay per visit. Preauthorization required.	Not covered	100% covered	100% covered
Physical Therapy Visits	Plan pays 100% of Contract Rates	Basic Medical pays up to $25.50 per visit, up to a maximum of $300 per calendar year. Major Medical pays 80% of the remaining Allowed Amount after Deductible.	100% covered	100% covered
	Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity.			
Injections	Plan pays 100% of Contract Rates	Payable as an Office Visit and count toward the Office Visit maximum	100% covered	100% covered
	Must be supplied and administered by physician's office. Self-injectables are covered under Prescription Drug benefits.			
Chiropractic Care and Acupuncture	Not subject to the Deductible. Plan pays a $25.50 benefit per visit, no more than one visit per day, up to a combined maximum of		Not covered	Not covered

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MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
	$500 per calendar year for office visits and $150 per calendar year for x-ray and laboratory.			
Outpatient X-ray and Lab	Plan pays 100% of Contract Rates	Basic Medical pays 85% of the Allowed Amount, up to a maximum of $750 per accident or per calendar year for all illnesses. Major Medical pays 75% of the remaining Allowed Amount after Deductible.	100% covered	100% covered
Podiatry	You must use a podiatrist contracted with Podiatry Plan, Inc. You pay $65 for the first office visit, unless the visit is for emergency, trauma, or a diabetic condition. Thereafter, Plan pays 100% of Contract Rates. Limited to a maximum of 8 visits per calendar year. No benefits are paid for non-Podiatry Plan podiatrists. Outside California, use the BlueCard network.	Not covered	100% covered if referred by your primary care physician to a Kaiser podiatrist	100% covered if referred by your primary care physician to a UHC podiatrist
Special Podiatry Benefit	Not Applicable	A separate $120 calendar year benefit is available, regardless of whether you are enrolled in the Indemnity Medical Plan, Kaiser, or UHC. The benefit is for office calls and charges (including x-rays) by non-network providers incurred for the non-surgical treatment of chronic foot conditions such as weak or fallen arches, flat or pronated feet, hallux valgus, metatarsalgia, or foot strain, and toenail trimming and surgical treatment involving debridement of painful clavi.		
Obesity Bypass Surgery	Covered under hospital and surgical benefits if Preauthorized as Medically Necessary		Covered if determined Medically Necessary and authorized	Covered if determined Medically Necessary and authorized

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MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
Organ and Tissue Transplants	Covered only if transplant is performed at an Anthem Blue Cross-approved Center of Expertise, the transplant recipient is a Plan participant, and the transplant is Preauthorized. Under certain circumstances, donor search, organ or tissue procurement, and donor expenses are covered up to a combined lifetime maximum of $30,000.	Not covered	Must have referral to transplant facility. Subject to plan copayments and coverage.	Must have referral to transplant facility. Subject to plan copayments and coverage.
Reconstructive Surgery Following Mastectomy	100% covered for reconstruction of the breast on which a mastectomy is performed, surgery on the other breast to provide a symmetrical appearance, and prostheses and services in connection with physical complications of all stages of mastectomy, including lymphedemas			
Home Health Care	Plan pays 80% of Contract Rates	Plan pays 80% of Allowed Amount, not subject to Deductible	100% covered, up to 100 visits per calendar year	100% covered, up to 100 visits per calendar year
	Coverage is provided for Registered Nurse expenses or licensed vocational nurse when prescribed by a physician as being Medically Necessary. Preauthorization by Prudent Buyer/BlueCard is required. Services and supplies provided in lieu of the services that would have been covered under the Plan if confinement had been in a hospital or Skilled Nursing Facility are covered. Homemaker services are not covered.			
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS				
Provider Network	Coverage is administered by HMC HealthWorks (HMC). Before receiving treatments, contact HMC at 866-268-2510. Preauthorization is required for all inpatient treatments (except		Coverage is provided through Kaiser. Participants must use Kaiser facilities and providers.	Coverage is administered by HMC HealthWorks (HMC). Before receiving treatment, contact HMC at 866-268-

SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2022

MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
	emergency hospitalization), intensive outpatient programs, ECT, psychological testing, neuropsychological testing, and partial hospitalization.			2510. All services and treatments must be provided by HMC network providers. Services by non-HMC providers are not covered, except for Emergency services. Preauthorization is required for all inpatient treatments (except emergency hospitalization), intensive outpatient programs, ECT, psychological testing, neuropsychological testing, and partial hospitalization.
Mental Health Inpatient	Plan pays 100% of HMC Contract Rates	Plan pays 50% of Allowed Amount for the first 120 days. After 120 days, Plan pays 80% of the Allowed Amount.	100% covered	100% covered
Mental Health Outpatient	First 5 visits: 100% covered After 5th visit: $10 copay per office visit; other services at 100% of Contract Rates.	Plan pays $25.50 per visit, then 80% of the remaining Allowed Amount.	100% covered	100% covered
Substance Abuse Inpatient	Detoxification, Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program: Plan pays 100% of HMC Contract Rates	Detoxification, Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program: Plan pays 50% of Allowed Amount for the first 120 days. After 120 days, Plan pays 80% of the Allowed Amount.	Inpatient Detoxification: 100% covered. Transitional Residential Recovery Services: $100 copay per admission.	100% covered
Substance Abuse Outpatient	Plan pays 100% of HMC Contract Rates	Plan pays $25.50 per visit then 80% of the remaining Allowed Amount	100% covered	100% covered

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MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
MEDICAL SUPPLIES AND EQUIPMENT				
Outpatient Medical & Surgical Supplies	Plan pays 100% of Contract Rates	Basic Medical pays up to $21.25 per visit for supplies, splints, and dressings for surgery in a physician's office. No Major Medical is payable.	100% covered	100% covered
Orthopedic Appliances	Reimbursement of 100% of Contract Rates or Allowed Amount for purchase or rental prescribed by a physician, up to once each calendar year.			
Hearing Aids	For patients whose physician has certified a hearing loss that may be lessened by the use of a hearing aid. The Plan pays 80% of Allowed Amount for physician examination and instrument up to $750 maximum for each ear, not more often than once during any 12-month period.			
Durable Medical Equipment	Plan pays 80% of Contract Rates	Plan pays 80% of the Allowed Amount	100% covered during a stay in a hospital or Skilled Nursing Facility. Durable medical equipment for home use is generally covered in accordance with Kaiser's durable medical equipment formulary guidelines.	100% covered during a stay in a hospital or Skilled Nursing Facility
VISION AND ACCIDENTAL INJURY BENEFITS				
Pediatric Vision Care (up to age 19)	Routine eye exams are covered at 100%, up to $135 per exam. However, amounts paid for routine eye exams will reduce the annual frame and lens benefit. A $135 maximum benefit for frames and lenses each calendar year.		Kaiser pays 100% for routine eye exams The Fund provides a $135 maximum benefit for frames and lenses each calendar year. If you go outside your HMO for routine eye exams, the Fund will pay 100%, up to $135 per exam. However, amounts paid by the Fund for eye exams will reduce the $135 annual frame and lens benefit.	UHC pays 100% for routine eye exams

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MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
Adult Vision Care (age 19 and over)	A $135 maximum benefit for routine eye exams and/or frames and lenses each calendar year		A $135 maximum benefit for routine eye exams and/or frames and lenses each calendar year. If eye exam is obtained through Kaiser, the $135 Fund benefit can be used for frames and lenses. Routine eye exams obtained through Kaiser are covered at 100%.	A $135 maximum benefit for routine eye exams and/or frames and lenses each calendar year. If eye exam is obtained through UHC, the $135 Fund benefit can be used for frames and lenses. Routine eye exams through UHC are covered at 100%.
	Note: You are permitted to opt-out of vision coverage for yourself and your Dependents Contact the Fund Office for more information.			
Additional Accidental Injury Benefit	In addition to other Plan benefits, a maximum of $300 is payable for Contract Rates/Allowed Amounts for Medically Necessary services and supplies incurred within 90 days of an accident as a result of the accident		None	None

PRESCRIPTION DRUG BENEFITS				
	INDEMNITY MEDICAL PLAN	KAISER (NON-KAISER EMPLOYEES)	UNITEDHEALTHCARE	KAISER (KAISER EMPLOYEES)
Participating Pharmacy	All participants must use So CA Drug Fund Participating Pharmacies (see separate Directory at www.ufcwdrugtrust.org under “Downloads”)			Must use Kaiser pharmacies
Out-of-Pocket Maximum	None			
Maximum Days Supply	Maximum 30 days supply per prescription. For maintenance drugs in certain therapeutic classifications, a 90-day supply may be obtained.			Maximum 100 days supply per prescription

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PRESCRIPTION DRUG BENEFITS				
	INDEMNITY MEDICAL PLAN	KAISER (NON-KAISER EMPLOYEES)	UNITEDHEALTHCARE	KAISER (KAISER EMPLOYEES)
Generic Preventive Care Drugs (including FDA approved contraceptives)	Plan pays 100% for aspirin, fluoride supplement, folic acid, statin preventive medication, tobacco cessation products, breast cancer preventive medication, preparation products for colon cancer screening test, female contraceptives, and HIV pre-exposure prophylaxis (PrEP); prescription required for OTC available drugs. Brand name will be covered when a generic is unavailable or medically inappropriate, but must be authorized by OptumRx. Age and frequency limits apply.			100% covered, prescription required
Generic	$5 copay per prescription			$5 copay per prescription
Brand	$5 copay per prescription if no generic equivalent is available. $8 copay per prescription if a generic equivalent is available but your doctor indicates "dispense as written." If a generic equivalent is available, and your doctor does not indicate "dispense as written," you must pay the cost difference between the generic drug and the brand name drug plus the $8 copay.			$5 copay per prescription
Self-administered Injectables	Plan pays 80% of OptumRx's Contract Rate. Authorization required through OptumRx. **For UHC enrollees**: Injectables that are prescribed by UHC physicians and provided by UHC are covered at 100% by the UHC plan and are not covered under the Prescription Drug Plan.			$5 copay per prescription

DENTAL BENEFITS		
	INDEMNITY DENTAL PLAN	UNITED CONCORDIA
Choice of Provider	You may select any dentist of your choice. Using a Delta Dental PPO dentist will lower your out-of-pocket expenses.	You must use the United Concordia dental office in which you are enrolled
Calendar Year Deductible	$50 per person; $150 per family. Not applicable to routine preventative and diagnostic procedures.	None
Covered Charges	For Delta PPO dentists, the Plan pays the lesser of the Delta PPO Contract Rates or the amount listed in the Schedule of Allowances. For Delta Premier dentists, the Plan pays the lesser of the Delta Premier	See United Concordia's Schedule of Benefits

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2022

DENTAL BENEFITS		
	INDEMNITY DENTAL PLAN	UNITED CONCORDIA
	Filed Fees or the amount listed in the Schedule of Allowances. For non-Delta Dental dentists, the Plan pays the lesser of the amount billed by the dentist or the amount listed in the Schedule of Allowances. The Schedule of Allowances is established by the Trustees and adjusted annually (see separate schedule at www.ufcwdrugtrust.org under "Downloads").	
Annual Maximum Benefit	$1,800 per person per calendar year for adults age 19 and older	No maximum
Note: You are permitted to opt-out of dental coverage for yourself and your Dependents. Contact the Fund Office for more information.		

ORTHODONTIC BENEFITS		
	CONTRACTED ORTHODONTISTS	NON-CONTRACTED ORTHODONTISTS
Precertification Required	All treatment plans must be approved by the Plan's Orthodontic Consultant before treatment begins. If treatment begins before precertification, no benefits will be paid. Contact the Fund Office for more information.	
Full Treatment	The Plan allowance is $3,200. The Plan pays $3,000 of the Contract Rate after your copay of $200.	Plan pays 80% of charges, up to a maximum of $3,000
Limited Treatment	Plan pays 80% of the Contract Rate. You are responsible for the balance of the Contract Rate.	Plan pays 80% of charges, up to a maximum of $2,600
Phase One Treatment	The Plan allowance is $1,250. The Plan pays $1,050 of the Contract Rate after your copay of $200	Plan pays 75% of charges, up to a maximum of $2,500
Development Supervision	The Plan allowance is $270. The Plan pays $220 after your copay of $50.	Plan pays 80% of charges, up to a maximum of $270
Lifetime Maximum Benefit	$3,000	$3,000

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2022

PLAN EXCLUSIONS	
INDEMNITY MEDICAL PLAN	
Excluded Services	The Plan does not pay benefits for the following: ○ Charges in excess of Contract Rates or, as applicable, the Allowed Amount; ○ Replacement of artificial eyes; ○ Orthognathic surgery; ○ Cosmetic treatment or surgery and complications resulting from any such procedure, except for repair of damage caused by accidental bodily injury (restorative surgery performed during or following mutilative surgery which was required as a result of illness or injury is not considered cosmetic); ○ Charges made by relatives of anyone in the participant's household, except for Covered Charges which constitute out-of-pocket expenses to such providers; ○ Experimental treatment, procedures, and therapies and any complications arising from such treatment; ○ Custodial care regardless of the type of facility and/or provider; ○ Eye examinations (including refractions and fitting of glasses), hearing aids, health aids, artificial limbs, and orthopedic appliances, except as specifically covered; ○ Any supplies or services furnished by a hospital or facility operated by the U.S. Government or any authorized agency thereof, or furnished at the expense of such Government or agency; ○ Any expenses connected with any form of artificial insemination, any non-surgical treatment for infertility after diagnosis, any expenses connected with or resulting from surrogate mothers or sperm banks, or the reversal of voluntary infertility; ○ Services and supplies for which no charge is made, or for which one is not required to pay; ○ Any services or supplies not recommended and approved by a legally qualified physician or surgeon, dentist, mental health professional, podiatrist on the Podiatry Plan, Inc. panel, or chiropractor performing services within the legal scope of their practices; ○ Conditions covered by Workers' Compensation or incurred in the course of employment, including self-employment; ○ Penile prosthesis unless preauthorized by Anthem Blue Cross; ○ Pregnancy expenses of dependent children or expenses for conditions arising from pregnancy of dependent children, except preventive care expenses; ○ Surgical correction of refractive problems, including radial keratotomy, unless vision cannot be corrected through eyeglasses or contact lenses; ○ Expenses incurred for any condition where there exists no injury or sickness, except that this exclusion does not apply to benefits specifically provided, such as hospice care, sterilization procedures, and preventive care benefits;

SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2022

PLAN EXCLUSIONS	
INDEMNITY MEDICAL PLAN	
Excluded Services	○ Speech therapy, except from a PPO provider; ○ Take home drugs when discharged from the hospital; ○ Expenses incurred by a transplant donor who is not eligible under the Plan (except for benefits specifically provided); ○ Organ or tissue transplants performed at a facility that is not an Anthem Blue Cross Center of Expertise; ○ Expenses incurred by an organ or tissue donor when the transplant recipient is not a Plan participant. ○ Vocational testing, evaluation, and counseling; ○ Injuries resulting from any form of warfare or invasion; ○ No benefits will be provided for podiatric care received from a non-Podiatry Plan, Inc. podiatrist (if you live outside of California, no podiatry benefits will be provided, unless you use a BlueCard network podiatrist), except for the special podiatry benefit. In addition, benefits for podiatric care are limited to those specifically described; ○ Claims filed more than one year after the date on which services were incurred; and ○ Services or supplies that are not Necessary Treatment.
Third Party Liability	If a Participant obtains a recovery from a third party that is in any manner related to claims paid by the Fund, the Participant will reimburse the Fund from such recovery in an amount not in excess of the payments made or to be made by the Fund.
INDEMNITY DENTAL PLAN	
Excluded Services	Please read the Indemnity Schedule of Allowances for Dental Procedures (updated each January)
PRESCRIPTION DRUG PLAN	
Exclusions	Please contact the Fund Office.
Third Party Liability	If a participant obtains a recovery from a third party that is in any manner related to claims paid by the Fund, the participant will reimburse the Fund from such recovery in an amount not in excess of the payments made or to be made by the Fund.
KAISER, UNITEDHEALTHCARE, UNITED CONCORDIA DENTAL	
Excluded Services	Please refer to the Evidence of Coverage (EOC) provided by Kaiser, United Healthcare, and United Concordia.
Third Party Liability	Please refer to the Evidence of Coverage (EOC) provided by Kaiser, United Healthcare, and United Concordia.

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