SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE PLATINUM AND GOLD PLANS

As of January 1, 2022

This document is intended merely as a summary of the Gold and Platinum health care plans offered by the Southern California Drug Benefit Fund. For exclusions and restrictions, you should read the Summary Plan Description and the Evidence of Coverage (EOC) booklets provided by Kaiser, UnitedHealthcare, and United Concordia.

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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

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ELIGIBILITY RULES	
ELIGIBILITY REQUIREMENT	
All Employees	Once you are eligible, you must continue to work the Qualifying Hours during each month to maintain your eligibility, to establish eligibility for other benefits, and to establish and/or maintain eligibility for your Dependents. You are also required to pay monthly (or weekly) contributions (also called "premiums") in order to maintain your coverage.
Employee Contribution/ Employee Premium	All Employees are required to pay premiums towards the cost of coverage. These premiums (also called "Employee Contributions") will generally be paid via payroll deduction (self-pay will be available for participants for whom a payroll deduction is not taken). You must complete an authorization form to allow your Employer to deduct your contribution amount and pay it to the Fund. Monthly Employee Contributions must be paid by the end of the month before the month of coverage. For example, for coverage in July, your contribution must be paid by the end of June. If your contributions are not timely paid, you will lose coverage. The amount of your monthly contribution is as follows: ➢ $34.67 per month ($8 per week) for Employee-only coverage. ➢ $52.00 per month ($12 per week) for Employee plus one or more children. ➢ $69.33 per month ($16 per week) for Employee plus spouse or Domestic Partner, with or without children. ***Note: You are permitted to opt-out of dental and/or vision coverage for yourself and your family. However, dropping your dental and/or vision coverage will not reduce your Employee premium. Contact the Fund Office for more information.***
WORKING SPOUSE RULE	
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.

MEDICAL PLAN OPTIONS
DEFINITIONS

This document is intended merely as a summary of the Gold and Platinum health care plans offered by the Southern California Drug Benefit Fund. For exclusions and restrictions, you should read the Summary Plan Description and the Evidence of Coverage (EOC) booklets provided by Kaiser, UnitedHealthcare, and United Concordia.

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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, and HMC) has agreed by contract to accept for services provided.
Covered Charges	The amount that the HMO has determined to be an appropriate charge for the service 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 treatment, your PPO is the **HMC HealthWorks (HMC) network**. Coverage is administered by HMC. Before receiving treatment, contact HMC at 866-268-2510. Preauthorization is required for all inpatient treatments (except emergency hospitalization), intensive outpatient programs, ECT, psychological testing, and neuropsychological testing. You must use an HMC provider; otherwise, there is no Plan coverage.
How the plan works	Generally, you must satisfy the Calendar Year Deductible ("Deductible") before the Plan pays any benefits. The expenses you pay for using a PPO provider, except copays for office visits and hospital stays, will apply toward the PPO Deductible. The expenses you pay for using a non-PPO provider, except for copays for hospital stays and charges that exceed the Allowed Amounts, will apply toward the non-PPO Deductible. After the required Deductible is satisfied, the Plan generally pays 80% of Contract Rates if you use a PPO provider and 50% of the Allowed Amount if you use a non-PPO provider. For some services and supplies, specific dollar limits are imposed that could result in the Fund paying less than these percentages. For each hospital stay, you must first pay a $100 copay. When you use a PPO facility, you are responsible for 20% of the remaining Contract Rates after the Plan pays 80% of the balance. When you use a non-PPO facility, the Plan pays 50% of the Allowed Amount, and you are responsible for the remaining 50% of the Allowed Amount plus any charges that exceed the Allowed Amount. PPO office visits are not subject to the Deductible. The Plan pays 100% of the Contract Rates after you pay a $20 copay per visit. When you use a PPO

MEDICAL PLAN OPTIONS	
	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 Deductible and no copay as long as the preventive services are received from PPO providers. For other PPO services, once your total medical out-of-pocket expenses have reached the Calendar Year Out-of-Pocket Maximum ("OOP Max"), the Plan generally will pay 100% of Contract Rates for the remainder of the calendar year. Your Deductible and certain other expenses do not count toward the OOP Max. There is no limit on out-of-pocket expenses when you use non-PPO Providers. When Preauthorization or Utilization Review is required, your doctor or hospital must contact Prudent Buyer/BlueCard at 800-274-7767. PPO physicians will do this automatically. You should confirm that your other providers, including non-PPO hospitals, have done this.
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, emergency procedures and benefits apply.
How the plan works (See Kaiser's Evidence of Coverage (EOC) for further details)	For most services, you pay a copay every time you use the service. However, hospital stays and outpatient surgery are subject to a Calendar Year Deductible ("Deductible"). For hospital stays and outpatient surgeries, once you have satisfied the Deductible, Kaiser will generally pay 80% of Covered Charges; you are responsible for the remaining 20%. Specific copays, coinsurance, and Deductible amounts are outlined below under "Medical Benefits." Once your out-of-pocket expenses reach the Calendar Year Out-of-Pocket Maximum ("OOP Max"), all care will generally be covered in full for the remainder of the calendar year. You must keep records (receipts) of your copays and coinsurance to provide as proof to Kaiser that you have reached your OOP Max.
HOW THE PLAN WORKS – UNITEDHEALTHCARE	
Provider Network	UHC offers a choice of three networks of providers – **Harmony, Alliance, and SignatureValue Advantage (SVA)**. You must choose one network, and all of your family members must be enrolled in the same network. You and your family members will have access only to providers in the network you choose. Each family member may individually select a primary care physician ("PCP") within the chosen network. If you do not choose a PCP, UHC will designate one for you. You may only change your network during Open Enrollment (unless you or a Dependent has certain special enrollment rights). The amount you pay for services depends on the provider network you choose. If you live in the service area of either the Harmony or the Alliance network, you will have the lowest out-of-pocket costs when you choose a primary care physician (PCP) in the Harmony or Alliance network. If you live in the Harmony or Alliance service area and you choose a PCP from the SignatureValue Advantage (SVA) network, you will have higher copayments and coinsurance. If you do not live within the service area of the Harmony or the Alliance network, you will participate and choose a PCP from the SVA network, and your

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MEDICAL PLAN OPTIONS	
	benefits will be the same as those under the Harmony and Alliance networks. You must use providers in your chosen network. Services rendered by a provider who is not in your chosen network are not covered, except for Emergency Services. **For mental health and substance abuse treatment, 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 (See UHC's Evidence of Coverage (EOC) for further details.)	You generally must satisfy the Calendar Year Deductible ("Deductible") before the plan pays any benefits. For most office visits, you pay a copayment. For other services, you will pay a percentage of Covered Charges (called "coinsurance"). Preventive care services, such as your annual physical exam, are covered at 100% with no copay and are not subject to the Deductible. Once you have paid the Calendar Year Out-of- Pocket Maximum ("OOP Max"), all care from UHC will generally be covered in full. You must keep records (receipts) of your copays and coinsurance to provide as proof to UHC that you have reached your OOP Max.

MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
CALENDAR YEAR DEDUCTIBLE, COINSURANCE, AND OUT-OF-POCKET (OOP) MAXIMUM				
Calendar Year Deductible ("Deductible")	$300 per person, $600 per family; may not be satisfied by office visit or hospital copays.	**Platinum Plan:** $1,000 per person, $2,000 per family **Gold Plan:** $2,000 per person, $4,000 per family Deductible may not be satisfied by hospital copays or charges that exceed the Fund's Allowed Amounts.	$300 per person, $600 per family. Applies to most services. Not applicable to doctor's office visits and preventive care. See Kaiser's EOC for more information.	$300 per person, $600 per family. Certain services will not be covered until you meet your Deductible. The Deductible applies to many services, including most inpatient services and outpatient surgery. It does not apply to preventive care, some outpatient services, and emergency or urgent care services. Only amounts incurred for covered services that are subject to the Deductible will count towards the Deductible. See UHC'S EOC for more information.
	Only amounts incurred for covered services that are subject to the Deductible will count towards the Deductible.			

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	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
Medical Out-of-Pocket Maximum Per Calendar Year ("OOP Max")	After the Deductible, participant coinsurance and copays accumulate to a total OOP Max of $2,000 per person, $6,000 per family (not including the Deductible). Premiums, non-covered expenses, charges in excess of benefit maximums, and expenses you pay for prescription drugs, vision, dental, hearing aids, chiropractic, and acupuncture do not count towards the OOP Max and are not paid by the Plan in the event you reach the OOP Max.	No maximum.	$2,000 per person, $4,000 per family (includes the Deductible). Premiums, non-covered expenses, charges in excess of benefit maximums, and expenses you pay for hearing aid, chiropractic and acupuncture (provided through the Fund), prescription drugs, vision care, and dental care do not count towards the OOP Max.	$2,000 per person, $4,000 per family (includes the Deductible). Premiums, non-covered expenses, charges in excess of benefit maximums, and copayments paid for certain Covered Services are not applicable to a Participant's Annual Copayment Maximum ("OOP Max"); these services are specified in UHC's Schedule of Benefits. Please refer to UHC's Schedule of Benefits for more information. In addition, expenses you pay for hearing aids, chiropractic and acupuncture (provided through the Fund), prescription drugs, vision care, and dental care do not count towards the OOP Max.
Plan Coinsurance and Participant Coinsurance	After you have satisfied the Deductible, the Plan pays 80% of Contract Rates for most services. You are responsible for the remaining 20% of Contract Rates. Refer to each benefit below for exceptions. For most services, the Plan will pay 100% of Contract Rates after you reach the medical OOP Max for the calendar year.	After you have satisfied the Deductible, the Plan pays 50% of the Allowed Amount for most services. You are responsible for the balance of the provider bill. Non-PPO providers often charge more than the Plan's Allowed Amount. When that happens, you are responsible for 50% of the Allowed Amount and 100% of any charges that exceed the Allowed Amount.	After the Deductible, Kaiser pays 80% of Covered Charges for services subject to coinsurance. You are responsible for 20% coinsurance until you reach your annual OOP Max. Services subject to coinsurance include, but are not limited to, inpatient hospitalization, outpatient surgery, inpatient mental health, inpatient chemical dependency, and emergency room visits.	Applies to inpatient hospitalization and outpatient surgery. After you satisfy the Deductible, UHC will generally pay: ○ Harmony (H): 80% of Covered Charges ○ Alliance (A): 80% of Covered Charges ○ SVA if you live in H/A area: 75% of Covered Charges ○ SVA if you live out of H/A area: 80% of Covered Charges You are responsible for the remaining 20%-25% of Covered Charges until you reach your annual OOP Max.
Annual/Lifetime Maximum	None.	None.	None.	None.

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	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
HOSPITAL BENEFITS				
Hospital Inpatient Services (including Room and Board, Physician Hospital Visits, and Ancillary Services)	After the Deductible and $100 copay per admission, the Plan pays 80% of Contract Rates. Prudent Buyer/BlueCard providers are responsible for obtaining all Preauthorization and Utilization Review. Copay does not count toward Deductible.	After the Deductible and $100 copay per admission, the Plan pays 50% of the Allowed Amount. All hospital admissions must be preauthorized by Prudent Buyer/BlueCard, except for childbirth or emergency hospitalizations. You must notify Anthem within 72 hours of an emergency admission. Call 800-810-BLUE for Preauthorization (outside California). In California, call 800-274-7767. Benefits will be reduced if you fail to obtain Preauthorization. Copay does not count toward Deductible.	After the Deductible, Kaiser pays 80% of Covered Charges.	After the Deductible, UHC pays: ○ Harmony (H): 80% of Covered Charges ○ Alliance (A): 80% of Covered Charges ○ SVA if you live in H/A area: 75% of Covered Charges ○ SVA if you live out of H/A area: 80% of Covered Charges
Hospital Outpatient Facility Charges	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	After the Deductible, Kaiser pays 80% of Covered Charges.	After the Deductible, UHC pays: ○ Harmony (H): 80% of Covered Charges ○ Alliance (A): 80% of Covered Charges ○ SVA if you live in H/A area: 75% of Covered Charges ○ SVA if you live out of H/A area: 80% of Covered Charges
Ambulance	After the Deductible, the Plan pays 80% of Contract Rates/Allowed Amount if admitted or if the definition of "emergency" is satisfied; otherwise 50% of Contract Rates/Allowed Amount.		After the Deductible, $150 copay per trip.	UHC pays 100% of Covered Charges.

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	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
Skilled Nursing Facility (Medicare approved)	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	As prescribed at designated facilities. After the Deductible, Kaiser pays 80% of Covered Charges. Limited to 100 days per benefit period.	After the Deductible, UHC pays: ○ Harmony (H): 80% of Covered Charges ○ Alliance (A): 80% of Covered Charges ○ SVA if you live in H/A area: 75% of Covered Charges ○ SVA if you live out of H/A area: 80% of Covered Charges Limit of 100 consecutive days per calendar year from the first treatment per disability.
	Must be Preauthorized by Prudent Buyer/BlueCard. Limited to 240 days per disability.			
Emergency Room Services (Facility, Physician, and Ancillary Services)	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	After the Deductible, Kaiser pays 80% of Covered Charges.	○ Harmony (H): $100 copay/visit ○ Alliance (A): $100 copay/visit ○ SVA if you live in H/A area: $150 copay/visit ○ SVA if you live out of H/A area: $100 copay/visit
	Determination of PPO versus non-PPO will be made based on the status of the hospital.			
Urgent Care	$20 copay/visit, not subject to the Deductible. Copay does not count toward Deductible.	After the Deductible, the Plan pays 50% of the Allowed Amount.	$20 copay/visit.	Within your PCP's medical group: ○ Harmony (H): $25 copay/visit ○ Alliance (A): $25 copay/visit ○ SVA if you live in H/A area: $35 copay/visit ○ SVA if you live out of H/A area: $25 copay/visit Outside your PCP's medical group: ○ Harmony (H): $50 copay/visit ○ Alliance (A): $50 copay/visit ○ SVA if you live in H/A area: $75 copay/visit ○ SVA if you live out of H/A area: $50 copay/visit

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	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
Outpatient Surgical Centers	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount, up to a maximum of $350 per operation. Any charges in excess of this $350 maximum do not count toward the Deductible.	After the Deductible, Kaiser pays 80% of Covered Charges.	After the Deductible, UHC pays: ○ Harmony (H): 80% of Covered Charges ○ Alliance (A): 80% of Covered Charges ○ SVA if you live in H/A area: 75% of Covered Charges ○ SVA if you live out of H/A area: 80% of Covered Charges
	Must be Preauthorized by Prudent Buyer/BlueCard.			
PROFESSIONAL SERVICES				
Physician Office Visits (Primary Care, Specialist)	$20 copay/visit, not subject to the Deductible. Copay does not count toward the Deductible.	After the Deductible, the Plan pays 50% of the Allowed Amount.	$20 copay/visit.	○ Harmony (H): $25 copay/visit ○ Alliance (A): $25 copay/visit ○ SVA if you live in H/A area: $35 copay/visit ○ SVA if you live out of H/A area: $25 copay/visit
Telehealth Visits	$0 copay through Anthem Health Online.	Not available.	$0 copay	$0 copay
Surgeon, Assistant Surgeon, Anesthesiologist	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	After the Deductible, Kaiser pays 80% of Covered Charges.	Covered under Hospitalization.
Preventive Care Services	Plan pays 100% of Contract Rates, not subject to the Deductible. No copay is required.	After the Deductible, the Plan pays 50% of the Allowed Amount.	Kaiser pays 100% of Covered Charges, not subject to copay or Deductible.	UHC pays 100% of Covered Charges, not subject to copay or Deductible.
	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.			

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	PPO (In Network)	Non-PPO (Out of Network)		
Outpatient X-ray and Lab	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	For most x-rays and labs: After the Deductible, $10 copay per encounter. For MRI, Most CT, Pet Scans: After the Deductible, $50 copay per procedure.	When available through and authorized by your Participating Medical Group, UHC pays 100% of Covered Charges.
Speech Therapy Visits	$20 copay/visit, not subject to the Deductible. Limited to 24 visits per calendar year. Preauthorization is required.	Not covered.	After the Deductible, $20 copay/visit.	○ Harmony (H): $25 copay/visit ○ Alliance (A): $25 copay/visit ○ SVA if you live in H/A area: $35 copay/visit ○ SVA if you live out of H/A area: $25 copay/visit
Physical Therapy Visits	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	After the Deductible, $20 copay/visit.	○ Harmony (H): $25 copay/visit ○ Alliance (A): $25 copay/visit ○ SVA if you live in H/A area: $35 copay/visit ○ SVA if you live out of H/A area: $25 copay/visit
	Preauthorization required. Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity. Benefit payment is limited to a maximum of 25 visits per calendar year.			
Injections	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	Office visit copay may apply.	Office visit copay may apply.
	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 $500 per calendar year for office visits and $150 per calendar year for x-ray and laboratory.		Not covered.	Not covered.
Obesity Bypass Surgery	Covered under hospital and surgical benefits if Preauthorized as Medically Necessary.	Covered under Non-PPO hospital and Non-PPO surgical benefits (including non-PPO	Covered if determined Medically Necessary and authorized.	Covered if determined Medically Necessary and authorized.

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	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
		outpatient surgical centers) if Preauthorized as Medically Necessary.		
Organ and Tissue Transplants	After the Deductible, the Plan pays 80% of Contract Rates. 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. After the Deductible, subject to plan coinsurance and coverage.	Must have referral to transplant facility. Subject to plan Deductible, copays, coinsurance, and coverage.
Podiatry	You must use a podiatrist contracted by Podiatry Plan, Inc. You pay $65 for the first office visit, unless the visit is for emergency, trauma, or a diabetic condition. Thereafter the 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	$20 copay/visit. Referral is required.	○ Harmony (H): $25 copay/visit ○ Alliance (A): $25 copay/visit ○ SVA if you live in H/A area: $35 copay/visit ○ SVA if you live out of H/A area: $25 copay/visit

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	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
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.		
Reconstructive Surgery Following Mastectomy	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	After the Deductible, Kaiser pays 80% of Covered Charges.	After the Deductible, UHC pays: ○ Harmony (H): 80% of Covered Charges ○ Alliance (A): 80% of Covered Charges ○ SVA if you live in H/A area: 75% of Covered Charges ○ SVA if you live out of H/A area: 80% of Covered Charges
	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	The Plan pays 80% of Contract Rates, not subject to Deductible.	The Plan pays 80% of Allowed Amount, not subject to Deductible.	Kaiser pays 100% of Covered Charges, up to 100 visits per calendar year	UHC pays 100% of Covered Charges, 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.			
MEDICAL SUPPLIES AND EQUIPMENT				
Outpatient Medical & Surgical Supplies	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount, up to a maximum of $21.25.	After the Deductible, Kaiser pays 80% of Covered Charges.	UHC pays 100% of Covered Charges.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE PLATINUM AND GOLD PLANS – JANUARY 1, 2022

MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
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 (DME)	The Plan pays 80% of Contract Rates.	The Plan pays 80% of the Allowed Amount.	Kaiser pays 80% of Covered Charges (Deductible does not apply). DME for home use is generally covered based on with Kaiser's formulary guidelines.	UHC pays 100% of Covered Charges, up to a maximum of $5,000 per calendar year
MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS				
Provider Network and Preauthorization	Coverage is administered by HMC HealthWorks (HMC). Before receiving treatment, you are strongly encouraged to contact HMC at 866-268-2510. Preauthorization is required for all inpatient treatments (except emergency hospitalization), intensive outpatient programs, ECT, psychological testing, and neuropsychological testing.		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 866-268-2510. 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, and neuropsychological testing.
Mental Health Inpatient	After the Deductible, the Plan pays 80% of HMC Contract Rates.	After the Deductible, the Plan pays 50% of Allowed Amount.	After the Deductible, Kaiser pays 80% of Covered Charges.	After Deductible, the Plan pays 80% of HMC Contract Rates.
Mental Health Outpatient	$20 copay/visit, not subject to the Deductible; other services at 80% of HMC Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	$20 copay/individual visit or $10 copay/group visit, not subject to the Deductible.	$20 copay/visit, not subject to the Deductible.
Substance Abuse Inpatient	After the Deductible, the Plan pays 80% of HMC Contract Rates.	After the Deductible, the Plan pays 50% of Allowed Amount.	Detoxification: After the Deductible, Kaiser pays 80% of Covered Charges.	After the Deductible, the Plan pays 80% of HMC Contract Rates.
Substance Abuse Outpatient	$20 copay/visit, not subject to the Deductible; other services at 80% of HMC Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	$20 copay/individual visit or $5 copay/group visit, not subject to the Deductible.	$20 copay/visit, not subject to the Deductible.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE PLATINUM AND GOLD PLANS – JANUARY 1, 2022

MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
VISION AND ACCIDENTAL INJURY BENEFITS				
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.
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% of Covered Charges -for routine eye exams.	UHC pays 100% of Covered Charges 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.	
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% of Covered Charges (not subject to Deductible or copay).	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 subject to copays.
	Unused vision benefits from the previous year are rolled over for use in the current calendar year, but no more than $135 from a prior year can be rolled into any calendar year. *Note: You are permitted to opt-out of vision coverage for yourself and your Dependents. However, opting out of vision benefits will not change the amount of your Employee contribution/premiums.*			

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE PLATINUM AND GOLD PLANS – JANUARY 1, 2022

PRESCRIPTION DRUG BENEFITS	
Participating Pharmacy	All participants must use So CA Drug Fund Participating Pharmacies (see separate Directory at www.ufcwdrugtrust.org under "Downloads").
Calendar Year Deductible	None.
Out-of-Pocket Maximum	**Indemnity Medical Plan Enrollees**: $6,050 individual and $10,100 family per year for prescriptions filled at participating pharmacies **Kaiser/UHC Enrollees**: $6,550 individual and $13,100 family per year for prescriptions filled at participating pharmacies
Maximum Days Supply	Maximum 30 days supply per prescription. For maintenance drugs in certain therapeutic classifications, a 90-day supply may be obtained.
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.
Generic	**Platinum Plan**: $8 copay per prescription; **Gold Plan**: $12 copay per prescription.
Formulary Brand	**Platinum Plan**: $25 copay per prescription; **Gold Plan**: $30 copay per prescription. These copays are only applicable when no generic equivalent is available or if 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 applicable copay ($25 or $30).
Non-formulary Brand	**Platinum Plan**: $45 copay per prescription; **Gold Plan**: $50 copay per prescription.
Injectables	The 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% of Covered Charges by the UHC plan and are not covered under the Prescription Drug Plan.

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	$75 per person; $225 per family. Not applicable to routine preventative and diagnostic procedures.	None.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
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DENTAL BENEFITS		
	INDEMNITY DENTAL PLAN	UNITED CONCORDIA
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 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").	See United Concordia's Schedule of Benefits.
Annual Maximum Benefit	$2,000 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. However, opting out of dental benefits will not change the amount of your Employee contribution/premiums.		

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

PLAN EXCLUSIONS	
INDEMNITY MEDICAL PLAN	
Excluded Services	The Plan does not pay benefits for the following: ○ Charges in excess of Contract Rates or the Allowed Amount, as applicable; ○ Replacement of artificial eyes; ○ 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 that was required as a result of illness or injury is not considered cosmetic); ○ Orthognathic surgery;

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PLAN EXCLUSIONS	
INDEMNITY MEDICAL PLAN	
Excluded Services	○ 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; ○ 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 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; ○ 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;

SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE PLATINUM AND GOLD PLANS – JANUARY 1, 2022

PLAN EXCLUSIONS	
INDEMNITY MEDICAL PLAN	
Excluded Services	○ 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.
KAISER & UNITEDHEALTHCARE	
Excluded Services	Please refer to the Evidence of Coverage (EOC) provided by Kaiser and United Healthcare.
Third Party Liability	Please refer to the Evidence of Coverage (EOC) provided by Kaiser and United Healthcare.
INDEMNITY DENTAL PLAN	
Excluded Services	Please read the Indemnity Schedule of Allowances for Dental Procedures (updated each January).
UNITED CONCORDIA DENTAL PLAN	
Excluded Services	Please refer the Evidence of Coverage (EOC) booklet provided by United Concordia.
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.

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