# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2022

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## SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2022

| CONTACT INFORMATION | | |
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| Trust Fund Office | 877-999-8329 | www.ufcwdrugtrust.org |
| Anthem Blue Cross Prudent Buyer | 800-227-3641 | www.anthem.com/ca |
| BlueCard | 800-810-BLUE (800-810-2583) | www.bcbs.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 of California (PPOC) | 800-367-7762 | www.podiatryplan.com |
| UnitedHealthcare (UHC) | 800-624-8822 | www.MyUHC.com |

# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2022

| MEDICAL PLAN OPTIONS | |
|---|---|
| **DEFINITIONS** | |
| Contract Rates | The amount that the PPO Provider (Prudent Buyer Network or BlueCard) has agreed by contract to accept for the services provided. For Medicare-Eligible Participants, the Contract Rate is the Medicare allowance. |
| Allowed Amount | For non-PPO services, the Allowed Amount is the allowance that the Fund has determined to be an appropriate payment for the Medically Necessary service(s) rendered to the participant in the provider's geographic area. The Allowed Amount is never more than the provider's billed amount. For Medicare-Eligible Participants, the Allowed Amount is the Medicare allowance for the services provided. The Board of Trustees, or its designee, has discretion to determine the Allowed Amount. |
| **HOW THE PLAN WORKS – INDEMNITY MEDICAL** | |
| How the plan works | For visits to a PPO doctor, you pay a $20 copay per visit. Before the Plan pays other benefits, you must satisfy the Calendar Year Deductible ("Deductible"). Most of the expenses you pay for using a PPO provider will apply toward the PPO Deductible. Most of the expenses you pay for using a non-PPO Provider will apply toward the non-PPO Deductible.<br><br>After the 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 result in the Fund paying less than these percentages.<br><br>For hospital stays, you must first pay a $100 copay per admission. You are then responsible for 20% of Contract Rates if you use a PPO provider, or 50% of the Allowed Amount plus any charges that exceed the Allowed Amount if you use a non-PPO provider.<br><br>For PPO providers, once your out-of-pocket expenses have accumulated to the Calendar Year Out-Of-Pocket Maximum ("OOP Max"), the Plan will pay 100% of Contract Rates for most services for the remainder of the Calendar Year. Your Deductible and copays for PPO office visits and hospital stays do not count toward the OOP Max. There is no OOP Max when you use a non-PPO provider.<br><br>This Plan coordinates benefits on a non-duplication basis. For more information about this Plan's payment when a Participant has more than one health plan or insurance (including Medicare), see page 17. |
| Preferred Provider Network | If you live in California, your preferred provider network ("PPO") is the **Anthem Blue Cross Prudent Buyer** network.<br><br>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.<br><br>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 who 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.<br><br>To find a PPO doctor or hospital nearest you, call Anthem Blue Cross Prudent Buyer at 800-227-3641 or BlueCard Access at 800-810-BLUE. |

This summary shows the "100% coverage" level of benefits. Refer to the Levels of Coverage section on page 8 of the Summary Plan Description for Retirees and their Dependents to determine your percentage and how that percentage is applied to your benefits under the Fund plans.

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## SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2022

| MEDICAL PLAN OPTIONS | |
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| **HOW THE PLAN WORKS – UNITEDHEALTHCARE (UHC) (Non-Medicare)** | |
| How the plan works | Generally, you must satisfy the Calendar Year Deductible ("Deductible") before the plan pays any benefits. The Deductible is<br>$500 per individual ($1,000 per family).<br>UHC offers a choice of three networks of providers – **Harmony, Alliance, and SignatureValue Advantage (SVA)**. You must choose one network, and you and each of your enrolled family members must be in the same network.<br>You must use providers in your chosen network. Services rendered by a provider not in your network are not covered, except for Emergency Services. For most office visits, you pay a copay. For other services, you will pay a percentage of Covered Charges (called "coinsurance").<br>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 benefits will be the same as those under the Harmony and Alliance networks.<br>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 as proof of payment. |
| Preferred Provider Network | 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 copays and coinsurance.<br>Generally, you are not able to change networks until an open enrollment period.<br>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 benefits will be the same as those under the Harmony and Alliance networks.<br>Services rendered by a provider who is not in your chosen network are not covered, except for Emergency Services.<br>For mental health and substance abuse treatment, HMC HealthWorks (HMC) is your preferred provider network. |
| **HOW THE PLAN WORKS – KAISER (Non-Medicare)** | |
| How the plan works | For most services, you pay a copay every time you use the service. However, inpatient hospital stays and outpatient surgery are subject to a Calendar Year Deductible ("Deductible"). For inpatient hospital stays and outpatient surgeries, once you have satisfied the Deductible, Kaiser will generally pay 80% of the cost; you are responsible for the remaining 20%. Specific copays, coinsurance and Deductible amounts are outlined below.<br>Once your out-of-pocket expenses reach the Calendar Year Out-of-Pocket Maximum, 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 as proof of payment. |
| Preferred Provider Network | You must use a Kaiser provider. Services rendered by non-Kaiser providers are not covered.<br>If an emergency occurs outside of the HMOs' service areas, emergency procedures and benefits apply. |

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| MEDICAL PLAN OPTIONS | |
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| **HOW THE PLAN WORKS – UHC & KAISER (Medicare)** | |
| How the plan works | For **Kaiser**: you pay a $20 copay for each office visit and a $500 copay for each inpatient hospital stay.<br>For **UHC**: you pay a $20 copay for each office visit and a $500 copay for each inpatient hospital stay.<br>Once you have paid the Calendar Year Copay Maximum, all care will generally be covered in full. You must keep records (receipts) of your copays as proof. The HMOs do not keep a record of your copays. |
| Preferred Provider Network | You must use an HMO provider. Services rendered by non-HMO providers are not covered.<br>If an emergency occurs outside of HMO service areas, emergency procedures and benefits apply. |

| MEDICAL BENEFITS | | | | | |
|---|---|---|---|---|---|
| | INDEMNITY MEDICAL PLAN | | UNITEDHEALTHCARE (Non-Medicare) | KAISER (Non-Medicare) | UHC & KAISER (Medicare) |
| | PPO (In Network) | Non-PPO (Out-of- Network) | | | |
| **CALENDAR YEAR DEDUCTIBLE, COINSURANCE, AND OUT-OF-POCKET (OOP) MAX** | | | | | |
| Calendar Year Deductible ("Deductible") | $500 per person, $1,000 per family; may not be satisfied by office visit or hospital copays. | $2,000 per person, $4,000 per family; may not be satisfied by hospital copays or charges that exceed the Fund's Allowed Amounts. | $500 per person, $1,000 per family<br>Applies to many services, including most inpatient services and outpatient surgery. Does not apply to preventive care, most outpatient services, emergency services, and urgently needed services. | $500 per person, $1,000 per family<br>Applies to most services except doctor's office visits and a few other services. See Kaiser's Evidence of Coverage for more information. | Not applicable. |
| | | | Only amounts incurred for covered services that are subject to the Deductible will count towards the Deductible. For more information about which services are subject to the Deductible, please see the Evidence of Coverage. | | |

This summary shows the "100% coverage" level of benefits. Refer to the Levels of Coverage section on page 8 of the Summary Plan Description for Retirees and their Dependents to determine your percentage and how that percentage is applied to your benefits under the Fund plans.

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| | INDEMNITY MEDICAL PLAN | | UNITEDHEALTHCARE (Non-Medicare) | KAISER (Non-Medicare) | UHC & KAISER (Medicare) |
| | PPO (In Network) | Non-PPO (Out-of- Network) | | | |
| Calendar Year Out-of-Pocket Maximum ("OOP Max") | After the Deductible, $2,000 per person, $6,000 per family (not including the Deductible). Office visit and hospital copays, and certain other charges, do not apply toward OOP Max. | No maximum. | $2,000 per person, $4,000 per family, including the Deductible. Copays for certain types of Covered Charges do not apply toward the OOP Max. Please refer to the plan's Schedule of Benefits or Evidence of Coverage for more information. | $2,000 per person, $4,000 per family, including the Deductible. Copays for some Covered Charges do not apply toward the OOP Max. Refer to the plan's Schedule of Benefits or Evidence of Coverage for more information. | For **Kaiser**: $1,500 per person, $3,000 per family, including prescription drugs.<br>For **UHC**: $6,700 per person, including prescription drugs. |
| Covered Charges | Generally the Contract Rate for a specified service. | Generally the Allowed Amount for a specified service. | The amount that the UHC Provider has agreed by contract with UHC to accept for the services provided. | The amount that Kaiser has determined is a reasonable charge for the service provided. | The amount that the HMO provider has agreed by contract to accept for the services. |
| Lifetime Max | $1,000,000 per person; $2,000,000 per family. | | Unlimited | | |
| Plan Coinsurance | After you have satisfied the Deductible, the Plan pays 80% of Contract Rates for most services. Refer to each benefit below for exceptions. You are responsible for the balance. | After you have satisfied the Deductible, the Plan pays 50% of the Allowed Amount for most services. Refer to each benefit below for exceptions.<br>You are responsible for the balance of the provider bill. Non-PPO providers often charge more than the Plan's Allowed Amount. You are responsible for 50% of the Allowed Amount and 100% of any charges that exceed the Allowed Amount. | Applies largely to Inpatient Hospital and outpatient surgery. After you satisfy the Deductible, UHC will pay 80% of Covered Charges; but if enrolled in SVA in an area where Alliance or Harmony is available, 75% of Covered Charges.<br>You are responsible for the remaining 20% to 25% of Covered Charges until you reach your annual OOP Max. | After the Deductible, Kaiser will pay 80% of Covered Charges for services subject to Coinsurance. You are responsible for the remaining 20% until you reach the OOP Max.<br>Services subject to Coinsurance include, but are not limited to, Inpatient Hospitalization, Outpatient Surgery, Inpatient Mental Health, Inpatient Chemical Dependency, and emergency room visits. | Not applicable. |

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| | INDEMNITY MEDICAL PLAN | | UNITEDHEALTHCARE (Non-Medicare) | KAISER (Non-Medicare) | UHC & KAISER (Medicare) |
| | PPO (In Network) | Non-PPO (Out-of- Network) | | | |
| **HOSPITAL BENEFITS** | | | | | |
| Hospital Inpatient Services (including Room and Board, and Ancillary Services) | After the Deductible and $100 copay per admission, the Plan pays 80% of Contract Rates.<br>Prudent Buyer/BlueCard providers are responsible for obtaining all Utilization Review.<br>Copay does not count toward the Deductible or OOP Max. | After the Deductible and $100 copay per admission, the Plan pays 50% of the Allowed Amount.<br>All hospitalizations except childbirth or emergency admissions must be pre-authorized by Prudent Buyer/BlueCard at 800-274-7767. Benefits will be reduced if you fail to obtain required pre-authorization. Copay does not count toward the Deductible. | After the Deductible, UHC pays: 80% of Covered Charges; but if enrolled in SVA in an area where Alliance or Harmony is available, 75% of Covered Charges. | After the Deductible, Kaiser pays 80% of Covered Charges. | $500 copay per admission. |
| Skilled Nursing Facility (Medicare approved) | After the Deductible, the Plan pays 80% of Contract Rates. If not transferred directly from a hospital, the $100 copay per admission applies.<br>Copay does not count toward the Deductible or OOP Max. | After the Deductible, the Plan pays 50% of the Allowed Amount. If not transferred directly from a hospital, the $100 copay per admission applies. Copay does not count toward the Deductible. | After the Deductible, UHC pays:<br>80% of Covered Charges; but if enrolled in SVA in an area where Alliance or Harmony is available, 75% of Covered Charges.<br>Limited to 100 consecutive days per Calendar Year from the first treatment per disability. | As prescribed at designated facilities. After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges. Limited to 100 days per benefit period. | As prescribed at designated facilities. 100% covered.<br>For **Kaiser**: limited to 100 days per benefit period.<br>For **UHC**: limited to 100 days per Calendar Year from the first treatment per disability. |
| | Must be pre-authorized by Prudent Buyer/BlueCard. Limited to 240 days per disability. | | | | |

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|---|---|---|---|---|---|
| | INDEMNITY MEDICAL PLAN | | UNITEDHEALTHCARE (Non-Medicare) | KAISER (Non-Medicare) | UHC & KAISER (Medicare) |
| | PPO (In Network) | Non-PPO (Out-of- Network) | | | |
| Ambulance | After the Deductible, the Plan pays 80% of Contract Rates/Allowed Amount if admitted or if the definition of "emergency" is met; otherwise 50% of Contract Rates or Allowed Amount. Your out-of-pocket does not count towards the OOP Max. | | Paid in full. | After the Deductible, $150 copay per trip. | 100% covered if authorized. |
| Emergency Room (Facility, Physician and Ancillary Services) | After the Deductible, the Plan pays 80% of Contract Rates. | After the Deductible, if the patient has an "emergency medical condition," the Plan pays 80% of the Allowed Amount; otherwise 50% of the Allowed Amount after Deductible. | $100 copay per visit; but if enrolled in SVA in an area where Alliance or Harmony is available, $150 copay per visit.<br>Copay waived if admitted as inpatient. | After the Deductible, Kaiser pays 80% of Covered Charges. | $50 copay, waived if admitted as inpatient. |
| | Determination of PPO versus non-PPO will be made based on the status of the hospital. | | | | |
| Urgent Care (After-hour office visits) | $20 copay per visit, not subject to the Deductible. Copay does not count toward the Deductible or OOP Max. | After the Deductible, the Plan pays 50% of the Allowed Amount. | **Within Your Medical Group:** $20 copay per visit; but if enrolled in SVA in an area where Alliance or Harmony is available, $35 copay per visit.<br>**Outside of Your Medical Group:**<br>$50 copay per visit; but if enrolled in SVA in an area where Alliance or Harmony is available, $75 copay per visit. | $20 copay per visit. | $20 copay per visit. |
| 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, UHC pays 80% of Covered Charges; but if enrolled in SVA in an area where Alliance or Harmony is available, 75% of Covered Charges. | After the Deductible, Kaiser pays 80% of Covered Charges. | For **Kaiser**: $20 copay per visit for Medicare Retirees.<br>For **UHC**: 100% covered. |

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| | INDEMNITY MEDICAL PLAN | | UNITEDHEALTHCARE (Non-Medicare) | KAISER (Non-Medicare) | UHC & KAISER (Medicare) |
| | 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 a maximum of $350 per surgery. Charges in excess of this maximum do not count toward the Deductible or OOP Max. | After the Deductible, UHC pays: 80% of Covered Charges; but if enrolled in SVA in an area where Alliance or Harmony is available, 75% of Covered Charges. | After the Deductible, Kaiser pays 80% of Covered Charges. | For **Kaiser**: $20 copay per visit for Medicare Retirees.<br>For **UHC**: 100% covered. |
| | Must be pre-authorized by Prudent Buyer/BlueCard. | | | | |
| **PROFESSIONAL BENEFITS** | | | | | |
| Physician Hospital 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, UHC pays: 80% of Covered Charges; but if enrolled in SVA in an area where Alliance or Harmony is available, 75% of Covered Charges. | After the Deductible, Kaiser pays 80% of Covered Charges. | 100% covered. |
| Physician and Specialist Office Visits | $20 copay per visit, not subject to the Deductible. Copay does not count toward the Deductible or OOP Max. | After the Deductible, the Plan pays 50% of the Allowed Amount. | $20 copay per visit; but if enrolled in SVA in an area where Alliance or Harmony is available, $35 copay per visit. | $20 copay per visit. | $20 copay per visit. |
| Surgeon, Assistant Surgeon, & Anesthetist | After the Deductible, the Plan pays 80% of Contract Rates. | After the Deductible, the Plan pays 50% of the Allowed Amount. | Covered under Hospitalization. | After the Deductible, plan pays 80% of Covered Charges. | 100% covered. |
| Outpatient X-ray and Laboratory | After the Deductible, the Plan pays 80% of Contract Rates. | After the Deductible, the Plan pays 50% of the Allowed Amount. | Generally paid in full. | Most x-rays and labs: $10 per encounter after Deductible. MRI, most CT and PET Scans: $50 per procedure after Deductible. | 100% covered. |
| | Not covered for physical exam purposes. | | | | |

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| | INDEMNITY MEDICAL PLAN | | UNITEDHEALTHCARE (Non-Medicare) | KAISER (Non-Medicare) | UHC & KAISER (Medicare) |
| | PPO (In Network) | Non-PPO (Out-of- Network) | | | |
| 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. | Office visit copay may apply. |
| | Must be supplied and administered by Physician's office. Self-injectables are covered under Prescription Drug benefits. | | | | |
| Physical Therapy Visits | After the Deductible, the Plan pays 80% of Contract Rates. Pre-authorization Required. | After the Deductible, the Plan pays 50% of the Allowed Amount. Pre-authorization Required. | $20 copay per visit; but if enrolled in SVA in an area where Alliance or Harmony is available, $35 copay per visit. | After the Deductible, $20 copay per visit. | $20 copay per visit. |
| | Benefit payment is limited to $2,500 per Calendar Year. Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity. | | | | |
| Speech Therapy Visits | $20 copay per visit, not subject to the Deductible. Limited to 24 visits per Calendar Year. Pre-authorization Required. Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity. | Not covered. | $20 copay per visit; but if enrolled in SVA in an area where Alliance or Harmony is available, $35 copay per visit. | After the Deductible, $20 copay per visit. | $20 copay per visit. |

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| | INDEMNITY MEDICAL PLAN | | UNITEDHEALTHCARE (Non-Medicare) | KAISER (Non-Medicare) | UHC & KAISER (Medicare) |
| | PPO (In Network) | Non-PPO (Out-of- Network) | | | |
| Chiropractic Care and Acupuncture | Plan pays $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. If not provided by a PPO provider, acupuncture is only covered when performed by a M.D. | | Not covered. | Not covered. | For **Kaiser**: Not covered, except manual manipulations to correct subluxation, if covered by Medicare.<br>For **UHC**: $20 copay, up to 12 visits maximum per Calendar Year. |
| 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, UHC pays 80% of Covered Charges; but if enrolled in SVA in an area where Alliance or Harmony is available, 75% of Covered Charges. | After the Deductible, Kaiser pays 80% of Covered Charges. | $500 copay per admission. |
| | Reconstruction of the breast on which a mastectomy is performed, surgery on the other breast to provide a symmetrical appearance, prostheses, and treatment of physical complications of all stages of mastectomy, including lymphedemas. | | | | |
| 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 pre-authorized. Subject to Deductible and Plan Coinsurance. 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 copays and/or coinsurance and coverage. Refer to your Evidence of Coverage for more information. | Must have referral to transplant facility. After Calendar Year Deductible, subject to plan coinsurance and coverage. | Must have referral to transplant facility. Subject to plan copays and coverage. |

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| | INDEMNITY MEDICAL PLAN | | UNITEDHEALTHCARE (Non-Medicare) | KAISER (Non-Medicare) | UHC & KAISER (Medicare) |
| | PPO (In Network) | Non-PPO (Out-of- Network) | | | |
| Podiatry | You must use a podiatrist on the Podiatry Plan Organization of California (PPOC) panel. You pay a $65 charge for the first office visit unless visit is for emergency, trauma, or a diabetic condition. The Plan pays 100% of Contract Rates thereafter, up to $300 per Calendar Year. No benefits are paid for non- PPOC podiatrists.<br>Outside California, use the BlueCard network. | Not Covered. | After the Deductible, $20 copay per visit; but if enrolled in SVA in an area where Alliance or Harmony is available, $35 copay per visit. | $20 copay per visit. Referral is required. | $20 copay per visit, if referred by your primary physician to a podiatrist. |
| 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. | | Not applicable. | | |
| Home Health Care | Registered nurse expenses or licensed vocational nurse when prescribed by a physician as being Medically Necessary covered at 68% of Contract Rates/Allowed Amounts. 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 convalescent facility are covered. Homemaker services are not covered. Coinsurance does not count towards the OOP Max. | | 100% covered up to 100 visits per Calendar Year. | 100% covered up to 100 visits per Calendar Year. | 100% covered. |

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| | INDEMNITY MEDICAL PLAN | | UNITEDHEALTHCARE (Non-Medicare) | KAISER (Non-Medicare) | UHC & KAISER (Medicare) |
| | PPO (In Network) | Non-PPO (Out-of- Network) | | | |
| Vision Care | Not covered. | | $20 copay per visit; but if enrolled in SVA in an area where Alliance or Harmony is available, $35 copay per visit. | Routine Eye Exams are covered through Kaiser at 100% (no Deductible or copay). | $20 copay for eye examination.<br>For **Kaiser**: $150 allowance for material every 24 months when prescribed by a Kaiser Physician or optometrist.<br>For **UHC**: no copay for one pair of Medicare- Covered eyeglasses or contact lenses after cataract surgery. |
| **PREVENTIVE MEDICINE** | | | | | |
| Physical Exam | For doctor's exam, $20 copay per visit, not subject to the Deductible. Copay does not count toward the Deductible or OOP Max. | The Plan pays 50% of the Allowed Amount up to $60 maximum per Calendar Year for doctor's exam. Age and frequency limits apply. | $20 copay per visit; but if enrolled in SVA in an area where Alliance or Harmony is available, $35 copay per visit. | Kaiser pays 100%, not subject to copay or the Deductible. | 100% covered. |
| | Outpatient x-ray and lab are not covered for physical exam purposes. | | | | |
| Pap & Pelvic Exam | $20 copay per visit, not subject to the Deductible. Copay does not count toward the Deductible or OOP Max. | After Deductible, the Plan pays 50% of the Allowed Amount. | $20 copay per visit; but if enrolled in SVA in an area where Alliance or Harmony is available, $35 copay per visit. | Kaiser pays 100%, not subject to copay or the Deductible. | $20 copay per visit. |
| Well Child Care | $20 copay per visit, not subject to the Deductible. Copay does not count toward the Deductible or OOP Max.<br>For age 6 or under only. | After the Deductible, the Plan pays 50% of the Allowed Amount up to $200 maximum per year until age 2, combined with immunization. | $20 copay per visit; but if enrolled in SVA in an area where Alliance or Harmony is available, $35 copay per visit. | Kaiser: Well-child preventive exams (through age 23 months) not subject to copay or the Deductible | 100% covered for child under 2 years old. |

This summary shows the "100% coverage" level of benefits. Refer to the Levels of Coverage section on page 8 of the Summary Plan Description for Retirees and their Dependents to determine your percentage and how that percentage is applied to your benefits under the Fund plans.

# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2022

| MEDICAL BENEFITS | | | | | |
|---|---|---|---|---|---|
| | INDEMNITY MEDICAL PLAN | | UNITEDHEALTHCARE (Non-Medicare) | KAISER (Non-Medicare) | UHC & KAISER (Medicare) |
| | PPO (In Network) | Non-PPO (Out-of- Network) | | | |
| Immunization | After the Deductible, the Plan pays 80% of Contract Rates. Must be for age 6 or under. If over age 6, only immunizations for school are covered. | After the Deductible, the Plan pays 50% of the Allowed Amount, up to $200 maximum per year until age 2, combined with Well Child Care. If age 2 and over, only immunizations for school are covered. | $20 copay per visit; but if enrolled in SVA in an area where Alliance or Harmony is available, $35 copay per visit. | Kaiser pays 100%, not subject to copay or the Deductible. | For **Kaiser**: Preventive Immunization Services (including the COVID-19 vaccine) at no charge.<br>For **UHC**: $20 copay per visit. |
| **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 $21.25 maximum. | 100% covered. | After Deductible, Kaiser pays 80% of Covered Charges. | 100% covered. |
| Durable Medical Equipment | The Plan pays 68% of Contract Rates. | The Plan pays 68% of the Allowed Amount. | 100% covered. | Payable at 80% of Covered Charges, not subject to Deductible. Durable medical equipment for home use is generally covered in accordance with Kaiser's durable medical equipment formulary guidelines. | For **Kaiser**: No charge in accordance with Kaiser's durable medical equipment formulary guidelines.<br>For **UHC**: 100% covered during a stay in a hospital or Skilled Nursing Facility. |

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# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2022

| MENTAL HEALTH BENEFITS | | | |
|---|---|---|---|
| | INDEMNITY MEDICAL PLAN | UNITEDHEALTHCARE | KAISER |
| **Non-Medicare** | Not covered. | Provided through the **Employee Member Assistance Program** administered by **HMC HealthWorks (HMC)**.<br>All services and treatments must be pre-authorized by HMC and provided by HMC network providers. No coverage for services and treatments by non-HMC approved providers. | Provided through **Kaiser**. Participants must use Kaiser facilities and providers. |
| Inpatient | | For information about benefits, please contact the Fund Office at (323) 666-8910, ext. 503. | For information about benefits, please contact Kaiser or the Fund Office at (323) 666-8910, ext. 503. |
| Outpatient | | For information about benefits, please contact the Fund Office at (323) 666-8910, ext. 503. | For information about benefits, please contact Kaiser or the Fund Office at (323) 666-8910, ext. 503. |
| **Medicare** | Not covered. | Provided through **UHC Medicare Advantage**. Participants must use UHC Medicare Advantage contract facilities and providers. | Provided through **Kaiser Senior Advantage.** Participants must use Kaiser facilities and providers. |
| Inpatient | | For information about benefits, please contact UHC or the Fund Office at (323) 666-8910, ext. 503. | For information about benefits, please contact Kaiser or the Fund Office at (323) 666-8910, ext. 503. |
| Outpatient | | For information about benefits, please contact UHC or the Fund Office at (323) 666-8910, ext. 503. | For information about benefits, please contact Kaiser or the Fund Office at (323) 666-8910, ext. 503. |

# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2022

<table>
<tr><th colspan="4">CHEMICAL DEPENDENCY BENEFITS</th></tr>
<tr><th></th><th>INDEMNITY MEDICAL PLAN</th><th>UNITEDHEALTHCARE</th><th>KAISER</th></tr>
<tr><td rowspan="2">Non-Medicare</td><td colspan="2">Coverage is provided through the Employee Member Assistance Program (EMAP) administered by HMC HealthWorks (HMC).<br><br>All services and treatments must be pre-authorized by HMC and provided by HMC network providers. No coverage for services and treatments by non-HMC approved providers.<br><br>Detoxification: The Plan pays 100% of HMC Contract Rates.</td><td rowspan="2">Coverage for treatment of Substance Abuse Disorders is provided through Kaiser. Participants must use Kaiser facilities and providers.<br><br>For information about benefits, please contact Kaiser or the Fund Office at (323) 666-8910, ext. 503.</td></tr>
<tr><td><u>Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program:</u> After the Deductible, Plan pays 80% of HMC Contracted Rate after a $100 copay per admission for inpatient services. Plan covers up to 3 treatments per lifetime. The second treatment must be at least 6 months after discharge from the first treatment. The third treatment must be at least 2 years after discharge from the second treatment.<br><br><u>Outpatient:</u> Plan pays 100% after a $20 copay per visit.</td><td>Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program:<br><br>For information about benefits, please contact the Fund Office at (323) 666-8910, ext. 503.</td></tr>
<tr><td>Medicare</td><td>Covered as above for Non-Medicare.<br><br>Coordination with Medicare applies.</td><td>Provided through UHC Medicare Advantage. Participants must use UHC Medicare Advantage contract facilities and providers.<br><br>For information about benefits, please contact UHC or the Fund Office at (323) 666-8910, ext. 503.</td><td>For information about benefits, please contact Kaiser or the Fund Office at (323) 666-8910, ext. 503.</td></tr>
</table>

This summary shows the “100% coverage” level of benefits. Refer to the Levels of Coverage section on page 8 of the Summary Plan Description for Retirees and their Dependents to determine your percentage and how that percentage is applied to your benefits under the Fund plans.

# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2022

| PRESCRIPTION DRUG BENEFITS | | | |
|---|---|---|---|
| | INDEMNITY PLAN<br>Non-Medicare and Medicare | UNITEDHEALTHCARE & KAISER<br>Non-Medicare | UNITEDHEALTHCARE & KAISER<br>Medicare |
| Participating Pharmacy | All Participants must use So CA Drug Fund Participating Pharmacies. (See separate Directory at www.ufcwdrugtrust.org under "Downloads.") | | Participants must use the HMO's pharmacies. |
| Calendar Year Deductible | $50 per person. | | None. |
| Maximum Days Supply | Maximum 30-day supply per prescription. For maintenance drugs in certain therapeutic classifications, a 90-day supply may be obtained. | | Maximum 30-day supply per prescription. For a maintenance drug, a 100-day supply for Kaiser or a 90-day supply for UnitedHealthcare may be obtained for two copays through mail order. |
| Generics | After Deductible, $12 copay per prescription. | | $10 copay per prescription. |
| Formulary Brand | After Deductible, $30 copay per prescription if 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 $30 copay. | | $25 copay per prescription. |
| Non-formulary Brand | After Deductible, $50 copay per prescription if 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 $50 copay. | | For **Kaiser Senior Advantage**: not covered. For **United Healthcare Medicare Advantage**: $40 copay per prescription. |
| Injectables | After Deductible, the Plan pays 80% of OptumRx's Contract Rate. Authorization required through OptumRx. | | Certain injectables are covered. |
| Maximum Benefit | $25,000 per person per Calendar Year. | | No maximum. |
| Medicare Part D<br>(Medicare eligibles only) | If you or your spouse/Domestic Partner enroll in an individual Medicare Part D plan, you will lose prescription drug coverage under the Retiree Health Plan. | | If you or your spouse/Domestic Partner enroll in an individual Medicare Part D plan, the HMO will terminate your coverage, and you and your eligible dependents will be transferred into the Indemnity Medical Plan provided by the Retiree Health Plan. Under the Indemnity Medical Plan, prescription drug coverage will not be available for retirees and/or dependents who have enrolled in an individual Medicare Part D plan. |

This summary shows the "100% coverage" level of benefits. Refer to the Levels of Coverage section on page 8 of the Summary Plan Description for Retirees and their Dependents to determine your percentage and how that percentage is applied to your benefits under the Fund plans.

# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2022

| COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS AND/OR MEDICARE | | |
|---|---|---|
| | INDEMNITY PLAN | UNITEDHEALTHCARE & KAISER |
| For All (Medicare and Non- Medicare) Participants | The Drug Fund Plan coordinates with other insurance plans, including Medicare, on a non-duplication basis. If the Drug Fund Plan is secondary and another plan is primary (such as Medicare), this Plan's benefits will be determined as follows:<br>○ If the primary plan's payment is less than the benefits that would be provided under this Plan if it were primary, then this Plan will pay the difference between its normal benefit and the amount paid by the primary plan.<br>○ If the primary plan's payment is the same or greater than the benefits provided by this Plan if it were primary, then this Plan will not pay any additional benefits. You will likely have some out-of-pocket expense, even though two plans are involved.<br>If a Medicare-eligible participant is covered under any other plan as an active employee or as a dependent of an active employee, that coverage would pay first, Medicare second, and this Plan third.<br>The Drug Fund's Indemnity Medical Plan does not pay for mental health, vision services, hearing aids, lab and x-rays related to physical exams, orthotics, orthopedic appliances, artificial limbs, and colostomy supplies, although they may be paid by Medicare. | You are required to provide information of your other coverage to Kaiser and UHC if you have coverage available through any government sponsor health programs or through your employer in addition to the coverage you have through the Drug Fund.<br>The Kaiser and UHC Plans for Non-Medicare participants will coordinate benefits on a Full Coordination basis with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care.<br>The Kaiser Senior Advantage and UHC Medicare Advantage Plans are Medicare Advantage with Prescription Drug Plans ("MA-PD Plans"). MA-PD Plans work like HMOs and coordinate with Medicare under Medicare rules. You pay the applicable copay for covered services. |
| Medicare Assignment (Part A, Part B, and Part D) | Participants who are eligible for Medicare must enroll with Medicare. The Plan does not pay for the Part B premium.<br>If you or your spouse enrolls in an individual Medicare Part D plan, you will lose prescription drug coverage under the Retiree Health Plan. | You must enroll with Medicare and assign your Part A, Part B, and Part D benefits to the MA-PD Plan. |

# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2022

| MEDICAL PLAN EXCLUSIONS | | |
|---|---|---|
| | INDEMNITY PLAN | UNITEDHEALTHCARE & KAISER |
| Excluded Services | The Plan does not pay benefits for the following:<br>○ Replacement of artificial eyes;<br>○ Orthognathic surgery;<br>○ Dental Care and dental x-rays, except for dental tumors;<br>○ Orthodontic care;<br>○ Cosmetic treatment or surgery and complications resulting from any such procedure, except for repair of damage caused by accidental bodily injury while eligible under the Plan (restorative surgery performed during or following mutilative surgery, which was required as a result of illness or injury, shall not be considered cosmetic);<br>○ Charges made by relatives of anyone in the Participant's household, except for covered charges which constitute out-of-pocket expenses to such providers;<br>○ Eye examinations (including refractions and fitting of glasses), hearing aids, health aids, artificial limbs, and orthopedic appliances, except as specifically covered;<br>○ Custodial care regardless of the type of facility and/or provider;<br>○ Experimental treatment, procedures, and therapies and any complications arising from such treatment;<br>○ 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;<br>○ 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;<br>○ Services and supplies for which no charge is made, or for which one is not required to pay;<br>○ Any services or supplies not recommended and approved by a legally qualified physician or surgeon, dentist, mental health professional, podiatrist on the PPOC panel, or chiropractor performing services within the legal scope of their practices;<br>○ Conditions covered by Workers' Compensation or incurred in the course of employment, including self-employment;<br>○ Speech therapy, except from a PPO provider; | Please refer to the Evidence of Coverage booklets provided by Kaiser and UHC. |

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| MEDICAL PLAN EXCLUSIONS | | |
|---|---|---|
| | INDEMNITY PLAN | UNITEDHEALTHCARE & KAISER |
| | ○ Pregnancy expenses of dependent children or expenses for conditions arising from pregnancy of dependent children;<br>○ Penile prosthesis, except when the cause of impotence is organic and then only if pre-authorized;<br>○ Surgical correction of refractive problems, including radial keratotomy, unless vision cannot be corrected through eyeglasses or contact lenses;<br>○ 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;<br>○ Treatment of nervous or mental disorders;<br>○ Take home drugs when discharged from the hospital;<br>○ Charges in excess of Contract Rates or the Allowed Amount, as applicable;<br>○ Organ or tissue transplants performed at a facility that is not an Anthem Blue Cross Center of Expertise;<br>○ Expenses incurred by an organ or tissue donor when the transplant recipient is not a Plan Participant;<br>○ Expenses incurred by a transplant donor who is not eligible under the Plan (except for benefits specifically provided);<br>○ Vocational testing, evaluation, and counseling;<br>○ Injuries resulting from any form of warfare or invasion;<br>○ No benefits will be provided for podiatric care received from a non-PPOC podiatrist (if you live outside of California, no podiatry benefits will be provided unless you use a BlueCard network podiatrist). In addition, benefits for podiatric care are limited to those specifically described;<br>○ Hearing aids, artificial limbs, orthotics, orthopedic appliances, and colostomy supplies;<br>○ Lab and x-rays related to physical exams;<br>○ Claims filed more than one year after the date on which services were incurred; and<br>○ Services or supplies that are not Necessary Treatment.<br><br>For Prescription Drug exclusions, please contact the Fund Office. | |

# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2022

| MEDICAL PLAN EXCLUSIONS | | |
|---|---|---|
| | INDEMNITY PLAN | UNITEDHEALTHCARE & KAISER |
| Amendment of Plan | All terms of the Retiree Health Plan are subject to amendment by the Board of Trustees or by the Unions and Retail Drug Employers. Benefits under the prepaid medical programs (HMOs) are also subject to amendments by the Trustees, the Unions and Employers, and the HMOs themselves. Benefits under the Plan are not vested. The continuation of retiree benefits depends on the continuation of Collective Bargaining Agreements, which require Employers to make contributions for these benefits.<br>Benefits will be continued to the extent that the Employer contributions provide for financing of these benefits. If contributions become insufficient to pay for all Plan benefits, benefits may be reduced or eliminated or the eligibility rules may be changed. Future Collective Bargaining Agreements may terminate the Plan. | |
| 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. | Please refer to the Evidence of Coverage booklets provided by Kaiser and UHC. |