SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

TABLE OF CONTENTS

CONTACT INFORMATION **2**

MEDICAL PLAN OPTIONS **3**

HOW THE PLAN WORKS – INDEMNITY MEDICAL 3

HOW THE PLAN WORKS – UNITEDHEALTHCARE (UHC) (Non-Medicare) 4

HOW THE PLAN WORKS – KAISER (Non-Medicare) 4

HOW THE PLAN WORKS – ANTHEM PPO, KAISER HMO, & UHC HMO (Medicare) 5

MEDICAL BENEFITS **6**

CALENDAR YEAR DEDUCTIBLE, COINSURANCE, AND OUT-OF-POCKET (OOP) MAX 6

HOSPITAL BENEFITS 9

PROFESSIONAL BENEFITS 13

PREVENTIVE MEDICINE 19

MEDICAL SUPPLIES AND EQUIPMENT 21

MENTAL HEALTH BENEFITS **22**

SUBSTANCE USE DISORDER BENEFITS **23**

PRESCRIPTION DRUG BENEFITS **25**

COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS AND/OR MEDICARE **26**

MEDICAL PLAN EXCLUSIONS **27**

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

CONTACT INFORMATION		
Trust Fund Office	877-999-8329	www.ufcwdrugtrust.org
Anthem Blue Cross Prudent Buyer Network (Non-Medicare)	800-227-3641	www.anthem.com/ca
BlueCard (Non-Medicare)	800-810-BLUE (800-810-2583)	www.bcbs.com
HMC HealthWorks (now Uprise Health)	866-268-2510	https://hmc.personaladvantage.com (Access Code: SCDBF)
Anthem PPO Plan (Medicare Advantage Plan)	833-848-8730	www.anthem.com/ca
Kaiser HMO (Medicare & Non-Medicare)	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) (Medicare & Non-Medicare Plan)	800-624-8822 **Medicare:** 844-481-8820	www.MyUHC.com **Medicare:** www.retiree.uhc.com

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, 2023

MEDICAL PLAN OPTIONS	
HOW THE PLAN WORKS – INDEMNITY MEDICAL (Non-Medicare Only)	
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. 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. 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. 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. 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 26.
Definition: Contract Rates	The amount that the PPO Provider (Prudent Buyer Network or BlueCard) has agreed by contract to accept for the services provided.
Definition: 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. The Board of Trustees, or its designee, has discretion to determine the Allowed Amount.
Preferred Provider Network	If you live in California, your preferred provider network ("PPO") is the **Anthem Blue Cross 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. For mental health and substance use disorder treatment, your preferred provider network is the **Uprise Health network (formerly known as HMC HealthWorks)**. For help finding a Uprise Health provider call Uprise Health at 866-268-2510. 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. 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.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

MEDICAL PLAN OPTIONS	
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 $500 per individual ($1,000 per family). UHC offers a choice of three networks of providers – **Harmony, Alliance, and SignatureValue (SV)**. You must choose one network, and you and each of your enrolled family members must be in the same network. 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"). 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. If there is a conflict between any description of benefits in this Summary and UHC's official Evidence of Coverage (EOC), or the Fund's contract with UHC, the EOC or the Fund's contract with UHC will control.
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 SV network, you will have higher copays and coinsurance. Generally, you are not able to change networks until an open enrollment period. 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 SV network, and your benefits will be the same as those under the Harmony and Alliance networks. 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, Uprise Health (formerly known as HMC HealthWorks or 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. 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. If there is a conflict between any description of benefits in this Summary and Kaiser's official Evidence of Coverage (EOC) or the Fund's contract with Kaiser, the EOC or the Fund's contract with Kaiser will control.
Preferred Provider Network	You must use a Kaiser provider. Services rendered by non-Kaiser providers are not covered, except for Emergency Services. If an emergency occurs outside of the HMOs' service areas, emergency procedures and benefits apply.

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, 2023

MEDICAL PLAN OPTIONS	
HOW THE PLAN WORKS – ANTHEM PPO, KAISER HMO, and UNITED HEALTHCARE HMO (Medicare)	
How the plan works	**For Anthem PPO**: The Anthem Medicare Preferred (PPO) Plan ("Anthem PPO Plan") generally covers items and services that are covered by Medicare. You pay a $500 deductible, a $20 copay for office visits and a $750 copay for each inpatient hospital stay. Once you have paid the Annual Out-of-Pocket Maximum, all care covered by the Plan will generally be covered in full. You must keep records (receipts) of your copays and coinsurance as proof of payment. Benefits provided under the Anthem PPO Plan are fully insured. If there is a conflict between any description of benefits in this Summary and the Anthem PPO's Plan's official Evidence of Coverage (EOC) or the Fund's contract with the Anthem PPO, the EOC or contract with the Anthem PPO will control. **For Kaiser**: you pay a $20 copay for each office visit and a $500 copay for each inpatient hospital stay. Once you have paid the Calendar Year Out-of-Pocket 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. **For UHC**: you pay a $20 copay for each office visit and a $500 copay for each inpatient hospital stay. Once you have paid the Calendar Year Out-of-Pocket 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. **For Kaiser & UHC**: If there is a conflict between any description of benefits in this Summary and Kaiser's or UHC's official Evidence of Coverage (EOC) or the Fund's contract with Kaiser or UHC, the EOC or the Fund's contract with the HMO will control.
Preferred Provider Network	For **Anthem PPO:** The Anthem PPO Plan generally covers items and services that are covered by Medicare. You can use any provider that will accept Medicare and the Anthem PPO Plan, whether in-network or out-of-network. Your copay and coinsurance will be the same, whether you use in-network or out-of-network providers, as long as the provider accepts Medicare and the Anthem PPO Plan. However, for some out-of-network Providers (OON Providers), you may have to pay the bill, then submit a claim to Anthem for reimbursement**.** The summary of benefits below does not describe all benefits or limitations on benefits. Please see your Evidence of Coverage or Medicare Advantage Enrollment Guide for more detailed information. For **Kaiser & UHC:** You must use an HMO provider. Services rendered by non-HMO providers are not covered, except for Emergency Services. If an emergency occurs outside of the HMO's service area, emergency procedures and benefits apply.

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, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO[1] (Non-Medicare)	KAISER HMO[1] (Non-Medicare)	ANTHEM PPO[2] (Medicare) (In or Out-of-Network)	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. 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. Applies to most services except doctor's office visits and a few other services. See Kaiser's Evidence of Coverage for more information.	$500 per person, combined in-network and out-of-network. Does not apply to covered preventive care, most outpatient services, emergency care, and urgently needed services. For more information about which services count towards the Deductible, see the Anthem PPO Plan's Evidence of Coverage (EOC).	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.			

[1] If there is a conflict between any description of HMO benefits in this Summary and the HMO's official Evidence of Coverage (EOC) or the Fund's contract with the HMO, the EOC or contract with the HMO will control.

[2] Please review Anthem's Evidence of Coverage for detailed benefits information. If there is a conflict between any of description benefits in this Summary and the Anthem PPO Plan's official Evidence of Coverage (EOC), the EOC will control.

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, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO[1] (Non-Medicare)	KAISER HMO[1] (Non-Medicare)	ANTHEM PPO[2] (Medicare) (In or Out-of-Network)	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.	$2,500 per person, does not include prescription drugs. Participant cost sharing for routine hearing services, routine vision services, and foreign travel emergency and urgently needed care do not apply to the OOP Max. In addition, Part D prescription drug deductibles and copays do not apply to the OOP Max.	**For Kaiser**: $1,500 per person, including prescription drugs. **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 Medicare allowance for the covered item or service or the amount that Anthem has determined is an appropriate charge.	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		Unlimited	

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare) (In or Out-of-Network)	UHC & KAISER (Medicare)
	PPO (In Network)	Non-PPO (Out-of-Network)				
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. 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 SV in an area where Alliance or Harmony is available, 75% of Covered Charges. 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. Services subject to Coinsurance include, but are not limited to, Inpatient Hospitalization, Outpatient Surgery, Inpatient Mental Health, Inpatient Chemical Dependency, and emergency room visits.	Generally, not applicable. However, after the Deductible, Anthem pays 90% for Medicare covered DME, prosthetics and orthotics, and 80% for one pair of glasses or contact lenses following Medicare-covered cataract surgery.	Not applicable.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare) (In or Out-of-Network)	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. Prudent Buyer/BlueCard providers are responsible for obtaining all Utilization Review. 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. All hospitalizations except childbirth and 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 SV in an area where Alliance or Harmony is available, 75% of Covered Charges.	After the Deductible, Kaiser pays 80% of Covered Charges.	After the Deductible, $750 copay per admission.[3] The inpatient hospital out-of-pocket maximum is $1,500 per year combined with inpatient mental health care (combined in-network and out-of-network).	$500 copay per admission.

[3] If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare) (In or Out-of-Network)	UHC & KAISER (Medicare)
	PPO (In Network)	Non-PPO (Out-of-Network)				
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. Copay does not count toward the Deductible or OOP Max. Must be pre-authorized by Prudent Buyer/ BlueCard. Limited to 240 days per disability.	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 80% of Covered Charges; but if enrolled in SV in an area where Alliance or Harmony is available, 75% of Covered Charges. 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.	After the Deductible, 100% covered for days 1-20, and $25 copay per day for days 21-100 per benefit period. Limited to 100 days per benefit period.	As prescribed at designated facilities. 100% covered. For **Kaiser**: limited to 100 days per benefit period. For **UHC**: limited to 100 days per Calendar Year from the first treatment per disability.
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 or Allowed Amount. Your out-of-pocket coinsurance does not count towards the OOP Max.		Paid in full.	After the Deductible, $150 copay per trip.	$100 copay per one-way trip. Your provider must get approval from Anthem for transportation that is not an emergency.	For **Kaiser**: 100% covered if authorized. For **UHC**: $50 copay per trip.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare) (In or Out-of-Network)	UHC & KAISER (Medicare)
	PPO (In Network)	Non-PPO (Out-of-Network)				
Emergency Room (Facility, Physician and Ancillary Services)	After the Deductible, the Plan pays 80% of Contract Rates. Determination of PPO versus non-PPO will be made based on the status of the hospital.	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.	$100 copay per visit; but if enrolled in SV in an area where Alliance or Harmony is available, $150 copay per visit. Copay waived if admitted as inpatient.	After the Deductible, Kaiser pays 80% of Covered Charges.	$120 copay, waived if admitted as inpatient within 72 hours for the same condition.	$50 copay, waived if admitted as inpatient within 24 hours.
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 SV in an area where Alliance or Harmony is available, $35 copay per visit. **Outside of Your Medical Group:** $50 copay per visit; but if enrolled in SV in an area where Alliance or Harmony is available, $75 copay per visit.	$20 copay per visit.	$20 copay per visit, waived if admitted to hospital within 72 hours for the same condition.	$20 copay per visit.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare) (In or Out-of-Network)	UHC & KAISER (Medicare)
	PPO (In Network)	Non-PPO (Out-of-Network)				
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 SV in an area where Alliance or Harmony is available, 75% of Covered Charges.	After the Deductible, Kaiser pays 80% of Covered Charges.	**For Surgery:** after the Deductible, $200 copay per visit for surgery or procedure; $200 copay for outpatient observation room visit. **For outpatient observation, non-surgical**: after the Deductible, $200 copay per outpatient observation room visit	For **Kaiser**: $20 copay per visit for Medicare Retirees. For **UHC**: 100% covered.
Outpatient Surgical Centers	After the Deductible, the Plan pays 80% of Contract Rates. Must be pre-authorized by Prudent Buyer/BlueCard.	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 SV in an area where Alliance or Harmony is available, 75% of Covered Charges.	After the Deductible, Kaiser pays 80% of Covered Charges.	After the Deductible, $200 copay per visit for surgery or procedure; $200 copay for outpatient observation room visit.	For **Kaiser**: $20 copay per visit for Medicare Retirees. For **UHC**: 100% covered.

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, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare) (In or Out-of-Network)	UHC & KAISER (Medicare)
	PPO (In Network)	Non-PPO (Out-of-Network)				
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 SV in an area where Alliance or Harmony is available, 75% of Covered Charges.	After the Deductible, Kaiser pays 80% of Covered Charges.	**Inpatient:** $0 copay for physician services received while an inpatient during a hospital stay.	100% covered.
Physician and Specialist Office Visits	$20 copay per visit, not subject to the Deductible. Copay does not count towards Deductible or OOP Max.	After the Deductible, the Plan pays 50% of the Allowed Amount.	$20 copay per visit; but if enrolled in SV in an area where Alliance or Harmony is available, $35 copay per visit.	$20 copay per visit.	$20 copay per visit.	$20 copay per visit.
Surgeon, Asst. 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.	100% covered.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

<table>
<tr><th colspan="6">MEDICAL BENEFITS</th></tr>
<tr><th></th><th colspan="3">NON-MEDICARE</th><th colspan="2">MEDICARE</th></tr>
<tr><th rowspan="2"></th><th colspan="2">INDEMNITY MEDICAL PLAN</th><th rowspan="2">UHC HMO
(Non-Medicare)</th><th rowspan="2">KAISER HMO
(Non-Medicare)</th><th rowspan="2">ANTHEM PPO
(Medicare)
(In or Out-of-Network)</th><th rowspan="2">UHC & KAISER
(Medicare)</th></tr>
<tr><th>PPO
(In Network)</th><th>Non-PPO
(Out-of-Network)</th></tr>
<tr><td>Outpatient X-ray and Laboratory</td><td>After the Deductible, the Plan pays 80% of Contract Rates.</td><td>After the Deductible, the Plan pays 50% of the Allowed Amount.</td><td>Generally paid in full.</td><td>Most x-rays and labs: $10 per encounter after Deductible.

MRI, most CT and PET Scans: $50 per procedure after Deductible.</td><td>Cost varies, depending on setting and test or service provided:
$35 copay for each x-ray and simple diagnostic test.
$0 copay for clinical/ diagnostic lab tests.
After the Deductible, $100 copay for complex diagnostic tests and radiology visits.
$0 copay for testing to confirm chronic obstructive pulmonary disease (COPD).</td><td>100% covered.</td></tr>
<tr><td></td><td colspan="2">Not covered for physical exam purposes.</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Injections</td><td>After the Deductible, the Plan pays 80% of Contract Rates.</td><td>After the Deductible, the Plan pays 50% of the Allowed Amount.</td><td>Office visit copay may apply.</td><td>Office visit copay may apply.</td><td>Office visit copay may apply.</td><td>Office visit copay may apply.</td></tr>
<tr><td></td><td colspan="2">Must be supplied and administered by Physician’s office. Self-injectables are covered under Prescription Drug benefits.</td><td></td><td></td><td></td><td></td></tr>
</table>

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

<table>
<tr><th colspan="7">MEDICAL BENEFITS</th></tr>
<tr><th></th><th colspan="3">NON-MEDICARE</th><th colspan="2">MEDICARE</th></tr>
<tr><th rowspan="2"></th><th colspan="2">INDEMNITY MEDICAL PLAN</th><th rowspan="2">UHC HMO
(Non-Medicare)</th><th rowspan="2">KAISER HMO
(Non-Medicare)</th><th rowspan="2">ANTHEM PPO
(Medicare)
(In or Out-of-Network)</th><th rowspan="2">UHC & KAISER
(Medicare)</th></tr>
<tr><th>PPO
(In Network)</th><th>Non-PPO
(Out-of-Network)</th></tr>
<tr><td>Physical Therapy Visits</td><td>After the Deductible, the Plan pays 80% of Contract Rates. Pre-authorization Required.

Benefit payment is limited to $2,500 per Calendar Year. Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity.</td><td>After the Deductible, the Plan pays 50% of the Allowed Amount. Pre- authorization Required.</td><td>$20 copay per visit; but if enrolled in SV in an area where Alliance or Harmony is available, $35 copay per visit.</td><td>After the Deductible, $20 copay per visit.</td><td>Outpatient services: $20 copay per visit.

Inpatient services: After the Deductible, $0 copay.</td><td>$20 copay per visit.</td></tr>
<tr><td>Speech Therapy Visits</td><td>$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.</td><td>Not covered.</td><td>$20 copay per visit; but if enrolled in SV in an area where Alliance or Harmony is available, $35 copay per visit.</td><td>After the Deductible, $20 copay per visit.</td><td>Outpatient services: $20 copay per visit.

Inpatient services: After the Deductible, $0 copay.</td><td>$20 copay per visit.</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, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare) (In or Out-of-Network)	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.	**Chiropractic Care:** Not covered, except manual manipulations to correct subluxation, if authorized by the Primary Care Physician. **Acupuncture:** Not covered.	**Chiropractic Care:** $20 copay per visit for Medicare-covered manual manipulation to correct subluxation. **Additional Chiropractic Services:** $20 copay per visit; limited to 20 visits per year. **Acupuncture:** $15 copay per visit for Medicare-covered acupuncture to treat chronic lower back pain. Limitations apply. **Additional acupuncture services**: $15 copay per visit. Limitations apply. See Anthem's Medicare Enrollment Guide for more information.	For **Kaiser**: Not covered, except manual manipulations to correct subluxation, if covered by Medicare. 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 SV in an area where Alliance or Harmony is available, 75% of Covered Charges.	After the Deductible, Kaiser pays 80% of Covered Charges.	**Inpatient:** $750 copay per admission; **Outpatient surgery:** $200 copay per surgery at outpatient hospital facility or outpatient surgical center.	$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.					

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare) (In or Out-of-Network)	UHC & KAISER (Medicare)
	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 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 approval by Medicare-approved transplant center. $750 copay per inpatient hospital admission.	Must have referral to transplant facility. Subject to plan copays and coverage.
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.			

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare) (In or Out-of-Network)	UHC & KAISER (Medicare)
	PPO (In Network)	Non-PPO (Out-of-Network)				
Podiatry	You must use a podiatrist on the Podiatry Plan, Inc. (formerly PPOC) panel. You pay a $65 charge for the first office visit unless visit is for emergency, trauma, or a diabetic condition. Plan pays 100% of Contract Rates thereafter, up to $300 per Calendar Year. No benefits are paid for non-Podiatry Plan podiatrists. Outside California, use the BlueCard network.	Not Covered.	After the Deductible, $20 copay per visit; but if enrolled in SV in an area where Alliance or Harmony is available, $35 copay per visit.	$20 copay per visit. Referral is required.	$20 copay per visit.	$20 copay per visit, if referred by your primary physician to a podiatrist.
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.	After the Deductible, 100% covered. A doctor must certify that home health care is needed. Durable Medical Equipment copay or coinsurance may apply.	100% covered.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare) (In or Out-of-Network)	UHC & KAISER (Medicare)
	PPO (In Network)	Non-PPO (Out-of-Network)				
Routine Vision Care	Not covered.		$20 copay per visit; but if enrolled in SV in an area where Alliance or Harmony is available, $35 copay per visit. Eyewear not covered.	Routine Eye Exams are covered through Kaiser at 100% (no Deductible or copay).	100% covered for routine vision exams and eyewear, limited to one routine vision exam per calendar year. Eyewear limited to a $100 maximum benefit every two calendar years. You are responsible for any remaining cost. See Evidence of Coverage for detailed description of benefits available for non-routine vision coverage.	$20 copay for eye examination. For **Kaiser**: $150 allowance for material every 24 months when prescribed by a Kaiser Physician or optometrist For **UHC**: no copay for one pair of Medicare-Covered eyeglasses after cataract surgery. No coverage for routine eyewear.
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 SV 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.	100% covered.
	Outpatient x-ray and lab are not covered for physical exam purposes.					

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare) (In or Out-of-Network)	UHC & KAISER (Medicare)
	PPO (In Network)	Non-PPO (Out-of-Network)				
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 SV 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, limited to one exam per 24 months (women at high risk limited to one exam every 12 months).	$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. 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 SV 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.	Not covered.	For **Kaiser:** Contact Kaiser for information. **UHC:** Not applicable unless the child has Medicare Parts A and B. Contact UHC for more information. .
Immunizations	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. At age 2 and over, only immunizations for school are covered.	$20 copay per visit; but if enrolled in SV 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 for certain preventive immunizations that are covered under Medicare Part B. Please review Anthem's Evidence of Coverage for more information.	For **Kaiser**: Preventive Immunization Services (including the COVID-19 vaccine) at no charge if received at the nurses' station. Office visit copay will apply if received during office visit. For **UHC**: $20 copay per visit. No charge for certain immunizations (Flu, Pneumococcal, Hepatitis B).

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare) (In or Out-of-Network)	UHC & KAISER (Medicare)
	PPO (In Network)	Non-PPO (Out-of-Network)				
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.	After the Deductible, Anthem pays 90% of Covered Charges for Medicare covered supplies.	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.	After the Deductible, Anthem pays 90% of Covered Charges for Medicare covered DME. For diabetic supplies, including blood glucose monitors, see Diabetes self-management section of Anthem's Medicare Advantage Enrollment Guide or Evidence of Coverage.	For **Kaiser**: No charge in accordance with Kaiser's durable medical equipment formulary guidelines. 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, 2023

MENTAL HEALTH BENEFITS					
	NON-MEDICARE			MEDICARE	
	INDEMNITY MEDICAL PLAN (Non-Medicare)	UHC HMO (Non-Medicare)	KAISER HMO (Non-Medicare)	ANTHEM PPO (Medicare)	KAISER & UHC (Medicare)
Mental Health Services – How to Access Care	Not covered.	Provided through the **Employee Member Assistance Program** administered by **HMC HealthWorks (HMC)**. 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. Inpatient services include Residential Treatment Centers.	Provided through **Kaiser**. Participants must use Kaiser facilities and providers.	Provided through the Anthem Medicare Preferred PPO Plan ("Anthem PPO Plan").	**Kaiser**: Provided through **Kaiser Senior Advantage.** Participants must use Kaiser facilities and providers. **UHC**: Provided through UHC Medicare Advantage. Participants must use UHC contracted facilities and providers.
Inpatient	Not covered.	After the Deductible, plan pays: 80% of Covered Charges.	After Deductible, Kaiser pays 80% of Covered Charges.	After the Deductible, $750 copay per admission.[4] *(The inpatient mental health care & SUD out-of-pocket maximum is $1,500 per year combined with inpatient hospital care.)*	**Kaiser**: $500 copay per hospital admission. (Residential mental Health treatment is covered at no charge). **UHC:** $500 copay per admission. Maximum 190 days per lifetime.
Outpatient	Not covered.	**Outpatient Office Visits:** $20 copay per visit. **All Other Outpatient Treatment:** No charge.	$20 copay per visit ($10 copay for group visits).	**Outpatient:** $20 copay for each individual or group therapy office visit; $20 copay for professional partial hospitalization visit.	**Kaiser:** $20 copay per visit ($10 copay for group visits). **UHC:** $20 copay per visit.

[4] If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at an in-network hospital.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

SUBSTANCE USE DISORDER ("SUD") BENEFITS					
	NON-MEDICARE			MEDICARE	
	INDEMNITY MEDICAL PLAN (Non-Medicare)	UHC HMO (Non-Medicare)	KAISER (Non-Medicare)	ANTHEM PPO (Medicare)	KAISER & UHC (Medicare)
Substance Use Disorders - How to Access Care	Coverage is provided through the **Employee Member Assistance Program (EMAP)** administered by **HMC HealthWorks (HMC)**. All services and treatments must be pre-authorized by HMC and provided by HMC network providers and facilities. No coverage for services and treatments by non-HMC approved providers.		Coverage for treatment of Substance Abuse Disorders ("SUD") is provided through **Kaiser**. Participants must use Kaiser facilities and providers. For information about benefits, please contact Kaiser at (833) 574-2273. After Hours: (800) 900-3277.	Provided through Anthem PPO Medicare Advantage Plan.	**Kaiser:** Coverage provided through **Kaiser Senior Advantage**. Participants must use Kaiser Senior Advantage contract facilities and providers. **UHC:** Provided through **UHC Medicare Advantage**. Participants must use UHC Medicare Advantage contract facilities and providers.
Inpatient Services	**Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program:** After the Deductible, Plan pays 80% of HMC Contract Rates 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. **Detoxification**: The Plan pays 100% of HMC Contract Rates.	**Inpatient Services – including Inpatient Medical Detoxification and Residential Treatment Centers:** After the Deductible, plan pays 80% of Covered Charges.	**Inpatient Detoxification and Residential Treatment Centers:** After the Deductible, Kaiser pays: 80% of Covered Charges.	**Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program:** After the Deductible, $750 copay per admission. *(The inpatient SUD and mental health care out-of-pocket maximum is $1,500 per year combined with inpatient hospital care.)*	**Kaiser:** Inpatient Detoxification: $500 copay per admission. Residential Treatment: $100 copay per admission. **UHC:** Inpatient Detoxification: $500 copay per admission.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

SUBSTANCE USE DISORDER ("SUD") BENEFITS					
	NON-MEDICARE			MEDICARE	
	INDEMNITY MEDICAL PLAN (Non-Medicare)	UHC HMO (Non-Medicare)	KAISER (Non-Medicare)	ANTHEM PPO (Medicare)	KAISER & UHC (Medicare)
Substance Use Disorders - Outpatient Services	**Outpatient:** Plan pays 100% after a $20 copay per visit.	**Office visits:** $20 copay per visit. **All other Outpatient Treatment:** No Charge	**Office visits:** $20 copay per visit ($5 copay for group visits).	**Outpatient:** $20 copay for each individual or group therapy office visit; $20 copay for professional partial hospitalization visit; $35 copay per visit for Opioid Treatment program services.	**Kaiser:** Outpatient SUD Evaluation & treatment: $20 copay per visit, or $5 copay per group SUD treatment. **UHC:** Outpatient Therapy: $20 copay per visit.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

PRESCRIPTION DRUG BENEFITS				
	NON-MEDICARE		MEDICARE	
	INDEMNITY PLAN (Non-Medicare)	UNITEDHEALTHCARE & KAISER (Non-Medicare)	ANTHEM PPO (Medicare)	UNITEDHEALTHCARE & KAISER (Medicare)
Participating Pharmacy	**All Participants must use So CA Drug Fund Participating Pharmacies**. (See separate Directory at www.ufcwdrugtrust.org under "Documents & Forms.")			Participants must use their 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 (Medicare eligibles only)	Not applicable.		If you or your spouse/Domestic Partner enroll in an individual Medicare Part D plan, Anthem will terminate coverage, and you will lose all 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 coverage, and you will lose all coverage under the Retiree Health Plan.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS AND/OR MEDICARE		
	INDEMNITY PLAN	ANTHEM, 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: ○ 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. ○ 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. 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. 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 about your other coverage to Anthem, Kaiser or UHC (as applicable) if you have coverage available through any government sponsor health programs or through an employer in addition to the coverage you have through the Drug Fund. 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. The Kaiser Senior Advantage and Anthem Medicare Advantage PPO 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 in Medicare Parts A and B. The Plan does not pay for the Part B premium. If you or your spouse enrolls in an individual Medicare Part D plan, you will lose prescription drug coverage under the Retiree Health Plan.	If you or any of your enrolled dependents are eligible for Medicare, you must enroll in Medicare Parts A and B, and assign your Part A, Part B, and Part D benefits to the MA-PD Plan.

MEDICAL PLAN EXCLUSIONS		
	INDEMNITY PLAN	ANTHEM, UNITEDHEALTHCARE & KAISER
Excluded Services	The Plan does not pay benefits for the following: ○ Replacement of artificial eyes; ○ Orthognathic surgery; ○ Dental Care and dental x-rays, except for dental tumors; ○ Orthodontic care; ○ 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); ○ Charges made by relatives of anyone in the Participant's household, except for covered charges which constitute out-of-pocket expenses to such providers; ○ Eye examinations (including refractions and fitting of glasses), hearing aids, health aids, artificial limbs, and orthopedic appliances, except as specifically covered; ○ Custodial care regardless of the type of facility and/or provider; ○ Experimental treatment, procedures, and therapies and any complications arising from such treatment; ○ 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 PPOC 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; ○ Speech therapy, except from a PPO provider;	Please refer to the Evidence of Coverage booklets provided by Anthem, Kaiser and UHC.

MEDICAL PLAN EXCLUSIONS		
	INDEMNITY PLAN	ANTHEM, UNITEDHEALTHCARE & KAISER
Excluded Services *(continued from prior page)*	The Plan does not pay benefits for the following: ○ Pregnancy expenses of dependent children or expenses for conditions arising from pregnancy of dependent children; ○ Penile prosthesis, except when the cause of impotence is organic and then only if pre-authorized; ○ 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; ○ Treatment of nervous or mental disorders; ○ Take home drugs when discharged from the hospital; ○ Charges in excess of Contract Rates or the Allowed Amount, as applicable; ○ 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; ○ Expenses incurred by a transplant donor who is not eligible under the Plan (except for benefits specifically provided); ○ 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-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; ○ Hearing aids, artificial limbs, orthotics, orthopedic appliances, and colostomy supplies; ○ Lab and x-rays related to physical exams; ○ Claims filed more than one year after the date on which services were incurred; and ○ Services or supplies that are not Necessary Treatment. For Prescription Drug exclusions, please contact the Fund Office.	

SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2023

MEDICAL PLAN EXCLUSIONS		
	INDEMNITY PLAN	ANTHEM, 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) and the insured Anthem PPO plan are also subject to amendments by the Trustees, the Unions and Employers, and by the HMO or the Insurer. 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. 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.