# SOUTHERN CALIFORNIA DRUG BENEFIT FUND

## SUMMARY OF THE PLATINUM PLUS PLAN

## As of January 1, 2023

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

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

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## SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2023

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| 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/home.html |
| BlueCard | 800-810-2583 (800-810-BLUE) | www.bcbs.com |
| Delta Dental | 800-765-6003 | www.deltadentalins.com |
| Uprise Health (formerly known as HMC HealthWorks) | 866-268-2510 | https://hmc.personaladvantage.com (Access Code: SCDBF) |
| Kaiser | 800-464-4000 | www.kp.org |
| OptumRx | 800-788-7871 | www.optumrx.com |
| Podiatry Plan, Inc. | 800-367-7762 | www.podiatryplan.com |
| United Concordia | 800-937-6432 | www.unitedconcordia.com |
| UnitedHealthcare (UHC) | 800-624-8822 | www.MyUHC.com |

# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2023

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

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

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

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| MEDICAL PLAN OPTIONS | |
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| | You are responsible for any remaining balance after the allowed Basic and Major Medical benefits are paid.<br><br>**Exception:** For claims subject to the No Surprises Act ("NSA Claims") (i.e., claims for non-PPO Emergency Services, certain non-emergency services furnished by non-PPO providers at PPO health facilities, and non-PPO air ambulance services), the Plan generally pays benefits at the PPO (In Network) coinsurance or copay amount (e.g., 100% of the Allowed Amount). You cannot be balance billed for any charges exceeding the Allowed Amount. See the "Claims Subject to the Federal No Surprises Act" row on page 6. *For more information on surprise billing protections, please refer to the notice entitled "Your Rights and Protections Against Surprise Medical Bills," available at www.ufcwdrugtrust.org (click on "Documents & Forms" and then click on the "Medical/Prescription" tab under "Documents") or by calling the Fund Office*. |
| **HOW THE PLAN WORKS – KAISER** | |
| Provider Network | You must use **Kaiser** providers. Services rendered by non-Kaiser providers are not covered. If an emergency occurs, emergency procedures and benefits apply.<br><br>**Exception:** Claims subject to the No Surprises Act ("NSA Claims") (i.e., claims for Emergency Services and certain services from an out-of-network/non-Kaiser provider at an in-network/Kaiser hospital or ambulatory surgical center) are treated as though furnished by Kaiser providers, in accordance with the federal No Surprises Act. See the "Claims Subject to the Federal No Surprises Act" row on page 6. *For more information on surprise billing protections, please refer to "What are my rights and protections related to the No Surprises Act (HR133)?" at https://healthy.kaiserpermanente.org/southern-california/support/pay-bills/medical-bills/no-surprises-act or call Kaiser*. |
| How the plan works | Hospital and professional services are generally provided at no charge if received at Kaiser facilities and provided by Kaiser providers. Refer to each benefit shown in the charts below for exceptions.<br><br>See Kaiser's Evidence of Coverage (EOC) for further details.<br><br>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. |
| **HOW THE PLAN WORKS – UNITEDHEALTHCARE** | |
| Provider Network | You must use UHC providers in the **SignatureValue (SV)** network. Services furnished by a provider who is not in the SV network are not covered, with the following exception: claims subject to the No Surprises Act ("NSA Claims") (i.e., claims for out-of-network Emergency Services, including air ambulance, and certain non-emergency services furnished by out-of-network providers at in-network health facilities) are treated as though furnished by in-network providers, in accordance with the federal No Surprises Act. See the "Claims Subject to the Federal No Surprises Act" row on page 6. For more information on surprise billing protections, please refer to "Federal Surprise Billing Notice" at www.uhc.com/legal/federal-surprise-billing-notice or call UHC.<br><br>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. |

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| MEDICAL PLAN OPTIONS | |
|---|---|
| | **For mental health and substance use disorder treatment, Uprise Health (formerly known as HMC HealthWorks) is your preferred provider network**. Coverage is administered by Uprise Health (formerly known as HMC). Before receiving treatment, contact Uprise Health at 866-268- 2510. All services and treatments must be provided by Uprise Health providers. Services rendered by a non-Uprise Health provider are not covered, except for Emergency Services. |
| How the plan works | Hospital and professional services are generally provided at no charge if received at HMO contracted facilities and provided by HMO providers. Refer to each benefit shown in the charts below for exceptions.<br>Preauthorization by **Uprise Health** (formerly known as **HMC**) is required for all services except outpatient therapy.<br>See UHC's Evidence of Coverage (EOC) for further details. |

| MEDICAL BENEFITS | | | | |
|---|---|---|---|---|
| | INDEMNITY MEDICAL PLAN | | KAISER | UNITEDHEALTHCARE |
| | PPO (In Network) | Non-PPO (Out of Network) | | |
| **CALENDAR YEAR DEDUCTIBLE, OUT-OF-POCKET (OOP) MAXIMUM, ANNUAL/LIFETIME MAXIMUM, PREAUTHORIZATION and UTILIZATION REVIEW, AND NSA CLAIMS** | | | | |
| Calendar Year Deductible ("Deductible") | None | $50 per person per calendar year before Major Medical pays. | None | None |
| Medical Out-of- Pocket Maximum Per Calendar Year ("OOP Max") | None | None | $1,500 per individual, $3,000 per family | $800 per individual, $2400 per family |
| Annual/Lifetime Maximum | None | None | None | None |
| Preauthorization and Utilization Review | When Preauthorization or Utilization Review is required, your doctor or hospital must contact PrudentBuyer/BlueCard. PPO providers will do this automatically. You should confirm that your other providers, including non-PPO hospitals, have done this. To obtain Preauthorization, call 800-274-7767 (in California) or 800-810-BLUE (outside California). | | See Kaiser's Evidence of Coverage | See UHC's Evidence of Coverage |

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| MEDICAL BENEFITS | | | | |
|---|---|---|---|---|
| | INDEMNITY MEDICAL PLAN | | KAISER | UNITEDHEALTHCARE |
| | PPO (In Network) | Non-PPO (Out of Network) | | |
| **Claims Subject to the Federal No Surprises Act ("NSA Claims")**<br>(Generally applicable to claims for out of network Emergency Services, certain non-emergency services furnished by out of network providers at in network health facilities, and out of network air ambulance services.) | Not applicable. | Your cost sharing is determined as if the service was furnished by a PPO (In Network) provider (i.e., the Plan generally pays 100% of the Allowed Amount or, for Hospital Inpatient Services after 120 days, 80% of the Allowed Amount).<br>The Allowed Amount is determined in accordance with federal law.<br>You cannot be balance billed. | Treated as though the services had been furnished by a Kaiser provider (generally 100% covered).<br>You cannot be balance billed.<br>See Kaiser's EOC or call Kaiser for more information. | Treated as though the services had been furnished by an in-network provider (generally 100% covered).<br>For Emergency Room Services: $35 copay/visit, waived if admitted as inpatient.<br>You cannot be balance billed.<br>See UHC's EOC or call UHC for more information. |
| **HOSPITAL BENEFITS** | | | | |
| Hospital Inpatient Services (including Room and Board and Ancillary Services) | Plan pays 100% of Contract Rates, up to 120 days per disability, including ICU and childbirth. After 120 days, Plan pays 80% of Contract Rates.<br>Prudent Buyer/BlueCard providers are responsible for obtaining all Preauthorization and Utilization Review. | Plan pays 50% of the Allowed Amount, up to 120 days per disability, including ICU only (excludes childbirth). After 120 days, Plan pays 80% of the Allowed Amount.<br>Prudent Buyer/BlueCard must Preauthorize all hospital admissions, except for childbirth or emergency hospitalizations. You must notify Anthem within 72 hours of an emergency admission. Call 800-274-7767 (in California) or 800-810-BLUE (outside California) for Preauthorization. Benefits will | 100% covered | 100% covered |

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| MEDICAL BENEFITS | | | | |
|---|---|---|---|---|
| | INDEMNITY MEDICAL PLAN | | KAISER | UNITEDHEALTHCARE |
| | PPO (In Network) | Non-PPO (Out of Network) | | |
| | | be reduced if you fail to obtain required Preauthorization. Unauthorized days are not covered. | | |
| Hospital Outpatient Facility Charges | Plan pays 100% of Contract Rates | Plan pays 85% of the Allowed Amount | 100% covered | 100% covered |
| Skilled Nursing Facility | Maximum benefit of 42.5% of the semiprivate room rate of the previous hospital stay, for up to 2 times the unused number of allowed days per disability. The number of allowed days is 120 days minus the number of days spent in the hospital.<br>Patient must be transferred into the Skilled Nursing Facility within 14 days of acute care hospital stay lasting at least 3 days. Must be approved by Prudent Buyer/BlueCard. | | As prescribed at designated facilities.<br>100% covered, limited to 100 days per benefit period. | As prescribed at designated facilities.<br>100% covered, limited to 100 days per calendar year from the first treatment per disability. |
| Emergency Room (Facility only, Physician charges are payable under Physician Hospital Visits) | Plan pays 100% of Contract Rates | Plan pays 100% of the Allowed Amount for Emergency Services (i.e., if the patient has an "Emergency Medical Condition"); otherwise 85% of the Allowed Amount (for accident) and 68% of the Allowed Amount (for illness). | 100% covered | $35 copay, waived if admitted as inpatient. Reasonable charges for emergency services received outside UHC service areas are covered subject to copayments. |
| | Determination of PPO versus non-PPO will be made based on the status of the hospital. Non-PPO Emergency Services subject to No Surprises Act (NSA). See page 4 for more information. | | | |
| Physician Hospital Visits | Plan pays 100% of Contract Rates | Basic Medical pays up to $25.50 per day. Major Medical pays 80% of the remaining Allowed Amount after Deductible. | 100% covered | 100% covered |

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| | INDEMNITY MEDICAL PLAN | | KAISER | UNITEDHEALTHCARE |
| | PPO (In Network) | Non-PPO (Out of Network) | | |
| Outpatient Surgical Centers | Plan pays 100% of Contract Rates | Plan pays a maximum of $350 per procedure. You are responsible for any charges that exceed $350, and these out-of-pocket charges do not count toward the Deductible. | 100% covered | 100% covered |
| | Must be Preauthorized by Prudent Buyer/BlueCard | | | |
| Ambulance | Plan pays 100% of Contract Rates/Allowed Amount | | 100% covered | 100% covered |
| **PROFESSIONAL SERVICES** | | | | |
| Office Visits | $10 copay per visit | Basic Medical pays up to $25.50 per visit, up to a maximum of $300 per calendar year. Benefits begin on the 1st visit for each accident and on the 2nd visit for each illness. After Basic Medical and Deductible have been satisfied, Major Medical pays 80% of the remaining Allowed Amount. | 100% covered | 100% covered |
| Telehealth Visits | $0 copay through Anthem Health Online | Not available | 100% covered | 100% covered |
| Preventive Care Services | Plan pays 100% of Contract Rates. No copay is required. | After the Deductible, Plan pays 85% of the Allowed Amount | 100% covered | 100% covered |
| | Coverage is provided for the services, screenings, and exams listed, and subject to the frequency described, in the Fund's Preventive Care Guidelines. Breast pumps must be purchased and obtained through a PPO Durable Medical Equipment vendor, | | | |

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| MEDICAL BENEFITS | | | | |
|---|---|---|---|---|
| | INDEMNITY MEDICAL PLAN | | KAISER | UNITEDHEALTHCARE |
| | PPO (In Network) | Non-PPO (Out of Network) | | |
| | otherwise there is no coverage. | | | |
| Specialist Office Visits | $10 copay per visit | Basic Medical pays up to $60 per visit for each accident or illness when referred by attending physician. No Major Medical is payable. | 100% covered | 100% covered |
| Surgeon, Assistant Surgeon | Plan pays 100% of Contract Rates | Basic Medical benefits are paid according to a schedule of charges. Excess charges, after Basic Medical and Deductible, are covered under Major Medical at 80% of the Allowed Amount. | 100% covered | 100% covered |
| Anesthesiologist | Plan pays 100% of Contract Rates | If provided in a hospital or outpatient surgical facility, Plan pays 85% of the Allowed Amount. If provided in a physician's office, Basic Medical pays $21.25 per visit and no Major Medical is payable. | 100% covered | 100% covered |
| Speech Therapy Visits | $10 copay per visit. Preauthorization required. | Not covered | 100% covered | 100% covered |
| Physical Therapy Visits | Plan pays 100% of Contract Rates | Basic Medical pays up to $25.50 per visit, up to a maximum of $300 per calendar year. Major Medical pays 80% of the remaining Allowed Amount after Deductible. | 100% covered | 100% covered |

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| MEDICAL BENEFITS | | | | |
|---|---|---|---|---|
| | INDEMNITY MEDICAL PLAN | | KAISER | UNITEDHEALTHCARE |
| | PPO (In Network) | Non-PPO (Out of Network) | | |
| | Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity. | | | |
| Injections | Plan pays 100% of Contract Rates | Payable as an Office Visit and counts toward the Office Visit maximum | 100% covered | 100% covered |
| | Must be supplied and administered by physician's office. Self-injectables are covered under Prescription Drug benefits. | | | |
| Chiropractic Care and Acupuncture | Not subject to the Deductible. Plan pays a $25.50 benefit per visit, no more than one visit per day, up to a combined maximum of $500 per calendar year for office visits and $150 per calendar year for x-ray and laboratory. | | Not covered | Not covered |
| Outpatient X-ray and Lab | Plan pays 100% of Contract Rates | Basic Medical pays 85% of the Allowed Amount, up to a maximum of $750 per accident or per calendar year for all illnesses. Major Medical pays 75% of the remaining Allowed Amount after Deductible. | 100% covered | 100% covered |
| Podiatry | You must use a podiatrist contracted with Podiatry Plan, Inc. You pay $65 for the first office visit, unless the visit is for emergency, trauma, or a diabetic condition. Thereafter, Plan pays 100% of Contract Rates. Limited to a maximum of 8 visits per calendar year. No benefits are | Not covered | 100% covered if referred by your primary care physician to a Kaiser podiatrist | 100% covered if referred by your primary care physician to a UHC podiatrist |

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| | INDEMNITY MEDICAL PLAN | | KAISER | UNITEDHEALTHCARE |
| | PPO (In Network) | Non-PPO (Out of Network) | | |
| | paid for non-Podiatry Plan podiatrists. Outside California, use the BlueCard network. | | | |
| Special Podiatry Benefit | Not Applicable | A separate $120 calendar year benefit is available, regardless of whether you are enrolled in the Indemnity Medical Plan, Kaiser, or UHC. The benefit is for office calls and charges (including x-rays) by out of network providers incurred for the non-surgical treatment of chronic foot conditions such as weak or fallen arches, flat or pronated feet, hallux valgus, metatarsalgia, or foot strain, and toenail trimming and surgical treatment involving debridement of painful clavi. | | |
| Obesity Bypass Surgery | Covered under hospital and surgical benefits if Preauthorized as Medically Necessary | | Covered if determined Medically Necessary and authorized | Covered if determined Medically Necessary and authorized |
| Organ and Tissue Transplants | Covered only if transplant is performed at an Anthem Blue Cross-approved Center of Expertise, the transplant recipient is a Plan participant, and the transplant is Preauthorized. Under certain circumstances, donor search, organ or tissue procurement, and donor expenses are covered up to a combined lifetime maximum of $30,000. | Not covered | Must have referral to transplant facility. Subject to plan copayments and coverage. | Must have referral to transplant facility. Subject to plan copayments and coverage. |
| Reconstructive Surgery Following Mastectomy | 100% covered for reconstruction of the breast on which a mastectomy is performed, surgery on the other breast to provide a symmetrical appearance, and prostheses and services in connection with physical complications of all stages of mastectomy, including lymphedemas | | | |
| Home Health Care | Plan pays 80% of Contract Rates | Plan pays 80% of Allowed Amount, not subject to Deductible | 100% covered, up to 100 visits per calendar year | 100% covered, up to 100 visits per calendar year |
| | Coverage is provided for Registered Nurse expenses or licensed | | | |

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| | INDEMNITY MEDICAL PLAN | | KAISER | UNITEDHEALTHCARE |
| | PPO (In Network) | Non-PPO (Out of Network) | | |
| | vocational nurse when prescribed by a physician as being Medically Necessary. Preauthorization by Prudent Buyer/BlueCard is required. Services and supplies provided in lieu of the services that would have been covered under the Plan if confinement had been in a hospital or Skilled Nursing Facility are covered. Homemaker services are not covered. | | | |
| **MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS** | | | | |
| Provider Network | Coverage is administered by Uprise Health (formerly known as HMC HealthWorks). Before receiving treatments, contact Uprise Health at 866-268-2510. Preauthorization by Uprise Health (formerly known as HMC) is required for all inpatient treatments (except emergency hospitalization), intensive outpatient programs, ECT, psychological testing, neuropsychological testing, and partial hospitalization. | | Coverage is provided through Kaiser. Participants must use Kaiser facilities and providers. | Coverage is administered by Uprise Health (formerly known as HMC HealthWorks). Before receiving treatment, contact Uprise Health at 866-268-2510. All services and treatments must be provided by Uprise Health (formerly known as HMC) network providers. All services except outpatient therapy must be preauthorized by Uprise Health. Services by non-Uprise Health providers are not covered, except for Emergency services. |
| Mental Health Inpatient | Plan pays 100% of Uprise Health Contract Rates | Plan pays 50% of Allowed Amount for the first 120 days. After 120 days, Plan pays 80% of the Allowed Amount. | 100% covered | 100% covered |
| Mental Health Outpatient | First 5 visits: 100% covered<br>After 5th visit: $10 copay per office visit; other services at 100% of Uprise Health Contract Rates. | Plan pays $25.50 per visit, then 80% of the remaining Allowed Amount. | 100% covered | 100% covered |

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|---|---|---|---|---|
| | INDEMNITY MEDICAL PLAN | | KAISER | UNITEDHEALTHCARE |
| | PPO (In Network) | Non-PPO (Out of Network) | | |
| Substance Use Disorder Inpatient | Detoxification, Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program: Plan pays 100% of Uprise Health Contract Rates | Detoxification, Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program: Plan pays 50% of Allowed Amount for the first 120 days. After 120 days, Plan pays 80% of the Allowed Amount. | Inpatient Detoxification: 100% covered. | 100% covered |
| Substance Use Disorder Outpatient | Plan pays 100% of Uprise Health Contract Rates | Plan pays $25.50 per visit then 80% of the remaining Allowed Amount | 100% covered | 100% covered |
| **MEDICAL SUPPLIES AND EQUIPMENT** | | | | |
| Outpatient Medical & Surgical Supplies | Plan pays 100% of Contract Rates | Basic Medical pays up to $21.25 per visit for supplies, splints, and dressings for surgery in a physician's office. No Major Medical is payable. | 100% covered | 100% covered |
| Orthopedic Appliances | Reimbursement of 100% of Contract Rates or Allowed Amount for purchase or rental prescribed by a physician, up to once each calendar year. | | | |
| Hearing Aids | For patients whose physician has certified a hearing loss that may be lessened by the use of a hearing aid. The Plan pays 80% of the Allowed Amount. for physician examination and instrument, up to $750 maximum for each ear, not more often than once during any 12-month period. | | | |
| Durable Medical Equipment | Plan pays 80% of Contract Rates | Plan pays 80% of the Allowed Amount | 100% covered during a stay in a hospital or Skilled Nursing Facility. Durable medical equipment for home use is generally covered in accordance with Kaiser's durable medical equipment formulary guidelines. | 100% covered during a stay in a hospital or Skilled Nursing Facility |

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# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2023

<table>
<tr><th colspan="5">MEDICAL BENEFITS</th></tr>
<tr><td rowspan="2"></td><td colspan="2">INDEMNITY MEDICAL PLAN</td><td rowspan="2">KAISER</td><td rowspan="2">UNITEDHEALTHCARE</td></tr>
<tr><td>PPO (In Network)</td><td>Non-PPO (Out of Network)</td></tr>
<tr><td colspan="5">VISION AND ACCIDENTAL INJURY BENEFITS</td></tr>
<tr><td rowspan="2">Pediatric Vision Care (up to age 19)</td><td colspan="2" rowspan="2">Routine eye exams are covered at 100%, up to $135 per exam. However, amounts paid for routine eye exams will reduce the annual frame and lens benefit.<br>A $135 maximum benefit for frames and lenses each calendar year.</td><td>Kaiser pays 100% for routine eye exams</td><td>UHC pays 100% for routine eye exams</td></tr>
<tr><td colspan="2">The Fund provides a $135 maximum benefit for frames and lenses each calendar year. If you go outside your HMO for routine eye exams, the Fund will pay 100%, up to $135 per exam. However, amounts paid by the Fund for eye exams will reduce the $135 annual frame and lens benefit.</td></tr>
<tr><td rowspan="2">Adult Vision Care (age 19 and over)</td><td colspan="2">A $135 maximum benefit for routine eye exams and/or frames and lenses each calendar year</td><td>A $135 maximum benefit for routine eye exams and/or frames and lenses each calendar year.<br>If eye exam is obtained through Kaiser, the $135 Fund benefit can be used for frames and lenses.<br>Routine eye exams obtained through Kaiser are covered at 100%.</td><td>A $135 maximum benefit for routine eye exams and/or frames and lenses each calendar year.<br>If eye exam is obtained through UHC, the $135 Fund benefit can be used for frames and lenses.<br>Routine eye exams through UHC are covered at 100%.</td></tr>
<tr><td colspan="4">Note: You are permitted to opt-out of vision coverage for yourself and your Dependents Contact the Fund Office for more information.</td></tr>
<tr><td>Additional Accidental Injury Benefit</td><td colspan="2">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</td><td>None</td><td>None</td></tr>
</table>

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# SOUTHERN CALIFORNIA DRUG BENEFIT FUND

## SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2023

| PRESCRIPTION DRUG BENEFITS | | | | |
|---|---|---|---|---|
| | INDEMNITY MEDICAL PLAN | KAISER (NON-KAISER EMPLOYEES) | UNITEDHEALTHCARE | KAISER (KAISER EMPLOYEES) |
| Participating Pharmacy | All participants must use So CA Drug Fund Participating Pharmacies (see separate "Participating Pharmacy Directory" at www.ufcwdrugtrust.org by first clicking on "Documents & Forms" and then clicking on the "Medical/Prescription" tab under "Documents") | | | Must use Kaiser pharmacies |
| Out-of-Pocket Maximum | None | | | |
| Maximum Days Supply | Maximum 30 days supply per prescription. For maintenance drugs in certain therapeutic classifications, a 90-day supply may be obtained. | | | Maximum 100 days supply per prescription |
| Generic Preventive Care Drugs (including FDA approved contraceptives) | Plan pays 100% for aspirin, fluoride supplement, folic acid, statin preventive medication, tobacco cessation products, breast cancer preventive medication, preparation products for colon cancer screening test, female contraceptives, and HIV pre-exposure prophylaxis (PrEP). Prescription required for OTC available drugs. Brand name will be covered when a generic is unavailable or medically inappropriate, but must be authorized by OptumRx. Age and frequency limits apply. | | | 100% covered, prescription required |
| Generic | $5 copay per prescription | | | $5 copay per prescription |
| Brand | $5 copay per prescription if no generic equivalent is available.<br>$8 copay per prescription if a generic equivalent is available, but your doctor indicates "dispense as written." If a generic equivalent is available, and your doctor does not indicate "dispense as written," you must pay the cost difference between the generic drug and the brand name drug plus the $8 copay. | | | $5 copay per prescription |
| Self-administered Injectables | Plan pays 80% of OptumRx's Contract Rate. Authorization required through OptumRx.<br>**For UHC enrollees**: Injectables that are prescribed by UHC physicians and provided by UHC are covered at 100% by the UHC plan and are not covered under the Prescription Drug Plan. | | | $5 copay per prescription |

| DENTAL BENEFITS | | |
|---|---|---|
| | INDEMNITY DENTAL PLAN | UNITED CONCORDIA |
| Choice of Provider | You may select any dentist of your choice. Using a Delta Dental PPO dentist will lower your out-of-pocket expenses. | You must use the United Concordia dental office in which you are enrolled |

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# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2023

| DENTAL BENEFITS | | |
|---|---|---|
| | INDEMNITY DENTAL PLAN | UNITED CONCORDIA |
| Calendar Year Deductible | $50 per person; $150 per family. Not applicable to routine preventative and diagnostic procedures. | None |
| Covered Charges | For Delta Dental PPO dentists, the Plan pays the lesser of the Delta Dental PPO Contract Rates or the amount listed in the Schedule of Allowances.<br>For Delta Premier dentists, the Plan pays the lesser of the Delta Premier Filed Fees or the amount listed in the Schedule of Allowances.<br>For non-Delta Dental dentists, the Plan pays the lesser of the amount billed by the dentist or the amount listed in the Schedule of Allowances.<br>The Schedule of Allowances is established by the Trustees and adjusted annually (see separate "2023 Platinum Plus Indemnity Dental Schedule" at www.ufcwdrugtrust.org by clicking on "Documents & Forms" and then clicking on the "Dental" tab under "Documents"). | See United Concordia's Schedule of Benefits |
| Annual Maximum Benefit | $1,800 per person per calendar year for adults age 19 and older | No maximum |
| *Note: You are permitted to opt-out of dental coverage for yourself and your Dependents. Contact the Fund Office for more information.* | | |

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

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# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2023

| ORTHODONTIC BENEFITS | | |
|---|---|---|
| | CONTRACTED ORTHODONTISTS | NON-CONTRACTED ORTHODONTISTS |
| Phase One Treatment | The Plan allowance is $1,250. The Plan pays $1,050 of the Contract Rate after your copay of $200. | Plan pays 75% of charges, up to a maximum of $2,500. |
| Development Supervision | The Plan allowance is $270. The Plan pays $220 after your copay of $50. | Plan pays 80% of charges, up to a maximum of $270. |
| Lifetime Maximum Benefit | $3,000 | $3,000 |

| PLAN EXCLUSIONS | |
|---|---|
| **INDEMNITY MEDICAL PLAN** | |
| Excluded Services | The Plan does not pay benefits for the following:<br>○ Charges in excess of Contract Rates or, as applicable, the Allowed Amount;<br>○ Replacement of artificial eyes;<br>○ Orthognathic surgery;<br>○ Cosmetic treatment or surgery and complications resulting from any such procedure, except for repair of damage caused by accidental bodily injury (restorative surgery performed during or following mutilative surgery which was required as a result of illness or injury is not considered cosmetic);<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>○ Experimental treatment, procedures, and therapies and any complications arising from such treatment;<br>○ Custodial care regardless of the type of facility and/or provider;<br>○ Eye examinations (including refractions and fitting of glasses), hearing aids, health aids, artificial limbs, and orthopedic appliances, except as specifically covered;<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; |

# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2023

| PLAN EXCLUSIONS | |
|---|---|
| **INDEMNITY MEDICAL PLAN** | |
| | ○ 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 Podiatry Plan, Inc. panel, or chiropractor performing services within the legal scope of their practices;<br>○ Conditions covered by Workers' Compensation or arising out of or incurred in the course of employment, including self-employment;<br>○ Penile prosthesis unless preauthorized by Anthem Blue Cross;<br>○ Pregnancy expenses of dependent children or expenses for conditions arising from pregnancy of dependent children, except preventive care expenses;<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; |
| Excluded Services | ○ Speech therapy, except from a PPO provider;<br>○ Take home drugs when discharged from the hospital;<br>○ Expenses incurred by a transplant donor who is not eligible under the Plan (except for benefits specifically provided);<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>○ 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-Podiatry Plan, Inc. podiatrist (if you live outside of California, no podiatry benefits will be provided, unless you use a BlueCard network podiatrist), except for the special podiatry benefit. In addition, benefits for podiatric care are limited to those specifically described;<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 unless expressly covered under the Plan, such as preventive care benefits. |
| Third Party Liability | If a Participant obtains a recovery from a third party that is in any manner related to claims paid by the Fund, the Participant will reimburse the Fund from such recovery in an amount not in excess of the payments made or to be made by the Fund. |
| **INDEMNITY DENTAL PLAN** | |
| Excluded Services | Please read the Indemnity Dental Schedule of Allowances for Dental Procedures (updated each January) |

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# SOUTHERN CALIFORNIA DRUG BENEFIT FUND
## SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2023

| PLAN EXCLUSIONS | |
|---|---|
| **INDEMNITY MEDICAL PLAN** | |
| **PRESCRIPTION DRUG PLAN** | |
| Exclusions | Please contact the Fund Office. |
| Third Party Liability | If a participant obtains a recovery from a third party that is in any manner related to claims paid by the Fund, the participant will reimburse the Fund from such recovery in an amount not in excess of the payments made or to be made by the Fund. |
| **KAISER, UNITEDHEALTHCARE, UNITED CONCORDIA DENTAL** | |
| Excluded Services | Please refer to the Evidence of Coverage (EOC) provided by Kaiser, United Healthcare, and United Concordia. |
| Third Party Liability | Please refer to the Evidence of Coverage (EOC) provided by Kaiser, United Healthcare, and United Concordia. |

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