SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2024

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CONTACT INFORMATION		
Trust Fund Office	877-999-8329	www.ufcwdrugtrust.org
Non-Medicare Plans		
Anthem Blue Cross Prudent Buyer Network	800-227-3641	www.anthem.com/ca
BlueCard	800-810-BLUE (800-810-2583)	www.bcbs.com
Uprise Health	866-268-2510	https://hmc.personaladvantage.com (Access Code: SCDBF)
Kaiser HMO	800-464-4000	www.kp.org
UnitedHealthcare HMO	800-624-8822	www.MyUHC.com
Medicare Plans		
Anthem Medicare Preferred (PPO)	833-848-8730	www.anthem.com/ca
Kaiser Senior Advantage	800-464-4000	www.kp.org
UnitedHealthcare Medicare Advantage	844-481-8820	retiree.uhc.com

This summary shows the "100% coverage" level of benefits. Refer to the Levels of Coverage section on page 6 of the Summary Plan Description for Retirees and their Dependents to determine your percentage and how that percentage is applied to your benefits under the Fund plans.

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HOW THE MEDICAL PLANS WORK	
INDEMNITY MEDICAL (Non-Medicare Only)	
"Contract Rates"	The amount that the PPO Provider (Prudent Buyer Network or BlueCard) has agreed by contract to accept for the services provided.
"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.
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 PPO is the **Uprise Health ("Uprise")** network. For help finding an Uprise provider call Uprise 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.
How the plan works	For visits to a PPO doctor, you pay a $20 copay/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/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.
KAISER (Non-Medicare)	
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.
How the plan works	For covered services, you pay the Deductible, copays, and coinsurance amounts applicable for each service. Once your out-of-pocket expenses reach the Calendar Year Out-of-Pocket Maximum, the Plan will pay for all covered services 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 EOC, the Kaiser EOC will control.

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HOW THE MEDICAL PLANS WORK	
UNITEDHEALTHCARE (UHC) HMO (Non-Medicare)	
Provider Network	UHC offers a choice of three networks of providers – **SignatureValue Harmony, SignatureValue Alliance, and SignatureValue (SV) HMO**. You must choose one network, and you and each of your enrolled family members must be in the same network. You and your family members will have access only to providers in the network you choose. Each family member may individually select a primary care physician ("PCP") within the chosen network. If you do not choose a PCP, UHC will designate one for you. You may only change your network during Open Enrollment (unless you or a Dependent has certain special enrollment rights). The amount you pay for services depends on the provider network you choose. If you live in the service area of either the Harmony or the Alliance network, you will have the lowest out-of-pocket costs when you choose a primary care physician (PCP) in the Harmony or Alliance network. If you live in the Harmony or Alliance service area, and you choose a PCP from the 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.
How the plan works	For covered services, you pay the Deductible, copays, and coinsurance amounts applicable for each service for the network you are enrolled in. Once your out-of-pocket expenses reach the Calendar Year Out-of-Pocket Maximum, the Plan will pay for all covered services in full for the remainder of the Calendar Year. If there is a conflict between any description of benefits in this Summary and UHC's EOC, the UHC EOC will control.
ANTHEM MEDICARE PREFERRED (PPO), KAISER SENIOR ADVANTAGE, and UHC MEDICARE ADVANTAGE	
Provider Networks	For **Anthem Medicare:** You can use any provider that will accept Medicare Payment, whether in-network or out-of-network. The deductible, copay and coinsurance will be the same whether you use in-network or out-of-network providers, as long as the provider accepts Medicare. However, for some out-of-network (OON) Providers, you may have to pay the bill, then submit a claim to Anthem for reimbursement**.** For **Kaiser Senior Advantage & UHC Medicare Advantage:** You must use an HMO provider. Services rendered by non-HMO providers are not covered, except for Emergency Services.
How the plans work	For **Anthem Medicare Preferred** (**PPO)**: For covered services, you pay the Deductible, copays, and coinsurance amounts applicable for each service. Once your out-of-pocket expenses reach the Calendar Year Out-of-Pocket Maximum, the Plan will pay for all covered services in full for the remainder of the Calendar Year. You must keep records (receipts) of your copays and coinsurance as proof of payment. For **Kaiser Senior Advantage**: For covered services, you pay the copay amounts applicable for each service. 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. **For UHC Medicare Advantage**: For covered services, you pay the copay amounts applicable for each service. 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. **See the Evidence of Coverage (EOC) for the Medicare Advantage Plan you are in for detailed benefits information.**

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MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO [1]	KAISER HMO [1]	ANTHEM [1]	UHC & KAISER [1]
	PPO (In Network)	Non-PPO (Out-of-Network)				
CALENDAR YEAR DEDUCTIBLE, PLAN COINSURANCE, LIFETIME MAXIMUM, AND OUT-OF-POCKET (OOP) MAX						
Covered Charges	Generally, the Contract Rate for a specified service.	Generally, the Allowed Amount for a specified service.	UHC's Contract Rate with a UHC provider for covered services.	The amounts determined by Kaiser for covered services.	The amounts determined by each respective carrier for covered services.	
Lifetime Max	$1,000,000/person; $2,000,000/family.		Unlimited		Unlimited	
Calendar Year Deductible ("Deductible")	$500/person, $1,000/family; may not be satisfied by copays.	$2,000/person, $4,000/family; may not be satisfied by copays or charges that exceed the Allowed Amount.	$500/person, $1,000/family. Only amounts incurred for covered services subject to the Deductible will count towards the Deductible. See the EOC for where deductible applies.	$500/person, $1,000/family.	$500/person, PPO and Non-PPO combined. See the EOC for services to which deductible applies.	Not applicable.
Plan Coinsurance	After you pay 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 until you reach the OOP max.	After you pay 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 50% of the Allowed Amount and 100% of any provider charges that exceed the Allowed Amount.	After you satisfy the Deductible, UHC will pay 80% of Covered Charges; but if enrolled in SV HMO in an area where Alliance or Harmony is available, 75% of Covered Charges. You are responsible for the balance 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 balance until you reach the OOP Max.	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.

[1] See the HMO/Medicare Advantage Plans' Evidence of Coverage for detailed benefits information. If there is a conflict between any description of HMO benefits in this Summary and the official Evidence of Coverage (EOC), the EOC will control.

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	INDEMNITY MEDICAL PLAN		UHC HMO [1]	KAISER HMO [1]	ANTHEM [1]	UHC & KAISER [1]
	PPO (In Network)	Non-PPO (Out-of-Network)				
Calendar Year Out-of-Pocket Maximum ("OOP Max")	After the Deductible, $2,000/person, $6,000/family (not including the Deductible). Copays and certain other charges, do not apply toward OOP Max.	No maximum.	$2,000/person, $4,000/family, including the Deductible. Copays for certain types of Covered Charges do not apply toward the OOP Max. See EOC for more information.	$2,000/person, $4,000/family, including the Deductible. Copays for some Covered Charges do not apply toward the OOP Max. See EOC for more information.	$2,500/person including prescription drug. Cost sharing for routine hearing services, routine vision services, foreign travel emergency and urgent care do not count toward the OOP Max.	**For Kaiser**: $1,000/person, including prescription drug. **For UHC**: $6,700/person, including prescription drug.
HOSPITAL BENEFITS						
Hospital Inpatient (including Room and Board, and Ancillary Services)	After the Deductible and $100 copay/admission, the Plan pays 80% of Contract Rates. PPO providers are responsible for obtaining pre-authorization or other Utilization Review. Copay does not count toward the OOP Max.	After the Deductible and $100 copay/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.	After the Deductible, UHC pays: 80% of Covered Charges; but if enrolled in SV where Alliance or Harmony is available, 75% of Covered Charges.	After the Deductible, Kaiser pays 80% of Covered Charges.	After the Deductible, $750 copay/admission.[2] The inpatient hospital out-of-pocket maximum is $1,500/year combined with inpatient mental health care (combined in-network and out-of-network).	$500 copay/admission.

[2] 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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	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO [1]	KAISER HMO [1]	ANTHEM [1]	UHC & KAISER [1]
	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/admission applies. Copay does not count toward OOP Max.	After the Deductible, the Plan pays 50% of the Allowed Amount. If not transferred directly from a hospital, the $100 copay/admission applies.	After the Deductible, UHC pays 80% of Covered Charges; but if enrolled in SV where Alliance or Harmony is available, 75% of Covered Charges. Limited to 100 consecutive days/Calendar Year from the first treatment/disability.	As prescribed at designated facilities. After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges. Limited to 100 days/benefit period.	After the Deductible, 100% covered for days 1-20, and $25 copay/day for days 21-100/benefit period. Limited to 100 days/benefit period.	As prescribed at designated facilities. 100% covered. For **Kaiser**: limited to 100 days/benefit period. For **UHC**: limited to 100 days/Calendar Year from the first treatment/disability.
	Must be pre-authorized by Prudent Buyer/ BlueCard. Limited to 240 days/disability.					
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 where Alliance or Harmony is available, 75% of Covered Charges.	After the Deductible, Kaiser pays 80% of Covered Charges.	After the Deductible, $200 copay/surgery; $200 copay/visit for observation room.	For **Kaiser**: $20 copay/visit for Medicare Retirees. For **UHC**: 100% covered.
Outpatient Surgical Centers	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays a maximum of $350/surgery. Excess Charges do not count toward the Deductible.	After the Deductible, UHC pays: 80% of Covered Charges; but if enrolled in SV where Alliance or Harmony is available, 75% of Covered Charges.	After the Deductible, Kaiser pays 80% of Covered Charges.	After the Deductible, $200 copay/visit for surgery or procedure; $200 copay for outpatient observation room visit.	For **Kaiser**: $20 copay/visit for Medicare Retirees. For **UHC**: 100% covered.
	Must be pre-authorized by Prudent Buyer/BlueCard.					

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	INDEMNITY MEDICAL PLAN		UHC HMO [1]	KAISER HMO [1]	ANTHEM [1]	UHC & KAISER [1]
	PPO (In Network)	Non-PPO (Out-of-Network)				
Ambulance	After the Deductible, the Plan pays 80% of Contract Rates/Allowed Amount if admitted or if the definition of "emergency" is satisfied; otherwise, 50% of Contract Rates or Allowed Amount. Your coinsurance does not count towards the OOP Max.		Paid in full.	After the Deductible, $150 copay/trip.	$100 copay/one-way trip. Must be approved by Anthem for non-emergency use.	For **Kaiser**: 100% covered if authorized. For **UHC**: $50 copay/trip.
Emergency Room (Facility, Physician and Ancillary Services)	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 80% of the Allowed Amount for emergency; 50% of the Allowed Amount for non-emergency.	$100 copay/visit; but if enrolled in SV where Alliance or Harmony is available, $150 copay/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.	$50 copay, waived if admitted as inpatient within 24 hours.
	Determination of PPO versus non-PPO will be made based on the status of the hospital.					
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 where Alliance or Harmony is available, 75% of Covered Charges.	After the Deductible, Kaiser pays 80% of Covered Charges.	100% covered.	100% covered.
Primary Care and Specialist Office Visits	$20 copay/visit, not subject to the Deductible.	After the Deductible, the Plan pays 50% of the Allowed Amount.	$20 copay/visit; but if enrolled in SV where Alliance or Harmony is available, $35 copay/visit.	$20 copay/visit.	$20 copay/visit.	$20 copay/visit.

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	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO [1]	KAISER HMO [1]	ANTHEM [1]	UHC & KAISER [1]
	PPO (In Network)	Non-PPO (Out-of-Network)				
Urgent Care (After-hour office visits)	$20 copay/visit, not subject to the Deductible.	After the Deductible, the Plan pays 50% of the Allowed Amount.	**Within Your Medical Group:** Same copay as office visits. **Outside of Your Medical Group:** $50 copay/visit; but if enrolled in SV where Alliance or Harmony is available, $75 copay/visit.	$20 copay/visit.	$20 copay/visit, waived if admitted to hospital within 72 hours for the same condition.	$20 copay/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.
Outpatient X-ray and Laboratory	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	Generally paid in full.	**Most x-rays and labs**: $10/encounter after Deductible. **MRI, most CT and PET Scans**: $50/procedure after Deductible.	**X-rays and simple lab**: $35 copay/encounter. **Complex radiology**: After the Deductible, $100 copay/encounter.	100% covered.
	Not covered for physical exam purposes.					
Injections	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	Office visit copay may apply.	Office visit copay may apply.	Office visit copay may apply.	Office visit copay may apply.
	Must be supplied and administered by Physician's office. Self-injectables are covered under Prescription Drug benefits.					
Physical Therapy Visits	After the Deductible, the Plan pays 80% of Contract Rates.	After the Deductible, the Plan pays 50% of the Allowed Amount.	$20 copay/visit; but if enrolled in SV in an area where Alliance or Harmony is available, $35 copay/visit.	After the Deductible, $20 copay/visit.	$20 copay/visit.	$20 copay/visit.
	Benefit payment is limited to $2,500/Calendar Year. Pre-authorization required. Subject to Utilization Review by Prudent Buyer/BlueCard.					

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	INDEMNITY MEDICAL PLAN		UHC HMO [1]	KAISER HMO [1]	ANTHEM [1]	UHC & KAISER [1]
	PPO (In Network)	Non-PPO (Out-of-Network)				
Speech Therapy Visits	$20 copay/visit. Limited to 24 visits/Calendar Year. Pre-authorization required.	Not covered.	$20 copay/visit; but if enrolled in SV where Alliance or Harmony is available, $35 copay/visit.	After the Deductible, $20 copay/visit.	$20 copay/visit.	$20 copay/visit.
Chiropractic Care and Acupuncture	Plan pays $25.50 benefit/visit, no more than one visit/day, up to a combined maximum of $500/Calendar Year for office visits and $150/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:** $20 copay for Medicare-covered treatment. For services not covered by Medicare, limited to 20 visits/year. **Acupuncture:** $15 copay for Medicare-covered treatment.	For **Kaiser**: Not covered, except manual manipulations to correct subluxation if covered by Medicare. For **UHC**: $20 copay, up to 12 visits per Calendar Year.
Organ and Tissue Transplants	Covered only if transplant is preauthorized and performed at an Anthem Blue Cross approved Center of Expertise, the transplant recipient is a Plan Participant. 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/inpatient hospital admission.	Must have referral to transplant facility. Subject to plan copays and coverage.

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	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO [1]	KAISER HMO [1]	ANTHEM [1]	UHC & KAISER [1]
	PPO (In Network)	Non-PPO (Out-of-Network)				
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 where Alliance or Harmony is available, 75% of Covered Charges.	After the Deductible, Kaiser pays 80% of Covered Charges.	$750 copay/admission.	$500 copay/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.					
Podiatry	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/Calendar Year.	Not Covered.	After the Deductible, $20 copay/visit; but if enrolled in SV in an area where Alliance or Harmony is available, $35 copay/visit.	$20 copay/visit. Referral is required.	$20 copay/visit.	$20 copay/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 those 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/Calendar Year.	100% covered up to 100 visits/Calendar Year.	After the Deductible, 100% covered.	100% covered.
Additional Accidental Injury Benefit	A maximum of $300 is payable 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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	INDEMNITY MEDICAL PLAN		UHC HMO [1]	KAISER HMO [1]	ANTHEM [1]	UHC & KAISER [1]
	PPO (In Network)	Non-PPO (Out-of-Network)				
Routine Vision Care	Not covered.		$20 copay/visit; but if enrolled in SV in an area where Alliance or Harmony is available, $35 copay/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 exam/calendar year. Eyewear limited to $100 maximum benefit every two calendar years.	$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	$20 copay/visit, not subject to the Deductible.	The Plan pays 50% of the Allowed Amount up to $60 per Calendar Year. Age and frequency limits apply.	$20 copay/visit; but if enrolled in SV in an area where Alliance or Harmony is available, $35 copay/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.					
Pap & Pelvic Exam	$20 copay/visit, not subject to the Deductible.	After Deductible, the Plan pays 50% of the Allowed Amount.	$20 copay/visit; but if enrolled in SV in an area where Alliance or Harmony is available, $35 copay/visit.	Kaiser pays 100%, not subject to copay or the Deductible.	100% covered, limited to one exam/24 months (women at high risk limited to one exam every 12 months).	100% covered.

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MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO [1]	KAISER HMO [1]	ANTHEM [1]	UHC & KAISER [1]
	PPO (In Network)	Non-PPO (Out-of-Network)				
Well Child Care	$20 copay/visit, not subject to the Deductible. For age 6 or under only.	After the Deductible, the Plan pays 50% of the Allowed Amount up to $200 per year until age 2, combined with immunization.	$20 copay/visit; but if enrolled in SV in an area where Alliance or Harmony is available, $35 copay/visit.	Preventive exams (through age 23 months) not subject to copay or Deductible.	Not covered.	For **Kaiser:** Contact Kaiser for information. **UHC:** Not applicable unless the child has Medicare. 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 per year until age 2, combined with Well Child Care. At age 2 and over, only immunizations for school are covered.	$20 copay/visit; but if enrolled in SV where Alliance or Harmony is available, $35 copay/visit.	100%c covered.	100% covered for certain preventive immunizations that are covered under Medicare Part B.	For **Kaiser**: Preventive Immunization Services at 100% if received at the nurses' station. For **UHC**: $20 copay/visit. No charge for Flu, Pneumococcal, Hepatitis B.
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 (DME)	The Plan pays 68% of Contract Rates.	The Plan pays 68% of the Allowed Amount.	100% covered.	Kaiser pays pays 80% of Covered Charges, not subject to Deductible; covered in accordance with Kaiser's DME formulary guidelines.	After the Deductible, Anthem pays 90% of Covered Charges for Medicare covered DME.	For **Kaiser**: No charge in accordance with Kaiser's DME formulary guidelines. For **UHC**: 100% covered in accordance with UHC's DME guidelines.

This summary shows the "100% coverage" level of benefits. Refer to the Levels of Coverage section on page 6 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, 2024

MEDICAL BENEFITS						
	NON-MEDICARE				MEDICARE	
	INDEMNITY MEDICAL PLAN		UHC HMO [1]	KAISER HMO [1]	ANTHEM [1]	UHC & KAISER [1]
	PPO (In Network)	Non-PPO (Out-of-Network)				
MENTAL HEALTH AND SUBSTANCE USE DISORDER ("SUD") BENEFITS						
Provider Network	Coverage is administered by **Uprise Health**. All services and treatments must be pre-authorized by Uprise and provided by Uprise providers and facilities. No coverage for services not approved by Uprise.		Provided through **UHC**. Participants must use UHC contracted facilities and providers.	Provided through **Kaiser**. Participants must use Kaiser facilities and providers.	Provided through **Anthem Medicare PPO**. .	Participants must use **Kaiser** or **UHC** facilities and providers.
Mental Health Inpatient	Not covered.		After the Deductible, UHC pays: 80% of Covered Charges.	After Deductible, Kaiser pays 80% of Covered Charges.	After the Deductible, $750 copay/admission.	**Kaiser**: $500 copay/ admission. **UHC:** $500 copay/ admission. Maximum 190 days/lifetime.
Mental Health Outpatient	Not covered.		Office Visits: $20 copay/visit. All Other Outpatient Treatment: No charge.	$20 copay/visit ($10 copay for group visits).	$20 copay/visit.	**Kaiser:** $20 copay/visit ($10 copay/group visit). **UHC:** $20 copay/visit.
SUD Inpatient	Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program: After the Deductible, Plan pays 80% of Covered Charges after a $100 copay/admission. Plan covers up to 3 treatments/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: Plan pays 100% of Contract Rates.		Detoxification and Residential Treatment Centers: After the Deductible, UHC pays 80% of Covered Charges.	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/admission.	**Kaiser:** Detoxification: $500 copay/admission. Residential Treatment: $100 copay/admission. **UHC:** Detoxification: $500 copay/admission.
SUD Outpatient	Plan pays 100% after a $20 copay/visit.		Office visits: $20 copay/visit. All other Outpatient Treatment: No Charge	$20 copay/visit ($5 copay for group visits).	$20 copay/visit; $35 copay/visit for Opioid Treatment program.	**Kaiser:** $20 copay/visit, or $5 copay/group visit. **UHC:** $20 copay/visit.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2024

PRESCRIPTION DRUG BENEFITS				
	NON-MEDICARE		MEDICARE	
	INDEMNITY PLAN	KAISER & UHC	ANTHEM PPO	KAISER & UHC
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/person.		None.	None.
Maximum Days Supply	30-day supply/prescription. For maintenance drugs in certain therapeutic classifications, a 90-day supply may be obtained.		30-day supply/prescription at retail pharmacy. 90-day supply/prescription for two copays through mail order.	30-day supply/prescription at pharmacy. 100-day supply for Kaiser or a 90-day supply for UHC for two copays through mail order.
Generics	After Deductible, $12 copay/prescription.		$0/prescription for selected generics. $10 copay/prescription for other generics.	$10 copay/prescription.
Formulary Brand	After Deductible, $30 copay/prescription if no generic equivalent is available or if your doctor indicates "dispense as written"; otherwise, you must pay the cost difference between the generic and the brand plus the $30 copay.		$20 copay/prescription	$25 copay/prescription.
Non-formulary Brand	After Deductible, $50 copay/prescription if no generic equivalent is available or if your doctor indicates "dispense as written"; otherwise, you must pay the cost difference between the generic and the brand plus the $50 copay.		$40 copay/prescription	**Kaiser Senior Advantage**: not covered. **UHC Medicare Advantage**: $40 copay/prescription.
Injectables	After Deductible, the Plan pays 80% of OptumRx's Contract Rate. Authorization required through OptumRx.		$100 copay/prescription	Certain injectables are covered.
Maximum Benefit	$25,000/person/Calendar Year.		No maximum.	No maximum.
Medicare Part D	Not applicable.		If you or your spouse/Domestic Partner enroll in an individual Medicare Part D plan, Anthem will disenroll you, 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 disenroll you, 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, 2024

COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS AND/OR MEDICARE		
	INDEMNITY PLAN	ANTHEM, KAISER, UHC
For All (Medicare and Non- Medicare) Participants	The Indemnity 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, 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.	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, Anthem Medicare Advantage PPO, and UHC Medicare Advantage Plans are Medicare Advantage with Prescription Drug Plans ("MAPD Plans"). MAPD Plans 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, KAISER, UHC
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;	Please refer to the Evidence of Coverage booklets provided by Anthem, Kaiser and UHC.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND
SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2024

MEDICAL PLAN EXCLUSIONS		
	INDEMNITY PLAN	ANTHEM, KAISER, UHC
Excluded Services *(continued from prior page)*	The Plan does not pay benefits for the following: ○ 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, 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; ○ 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; ○ 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.	

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE RETIREE PLAN – JANUARY 1, 2024

MEDICAL PLAN EXCLUSIONS		
	INDEMNITY PLAN	ANTHEM, KAISER, UHC
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.