SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE PLATINUM PLUS PLAN

As of January 1, 2024

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

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CONTACT INFORMATION		
Trust Fund Office	877-999-8329	www.ufcwdrugtrust.org
Anthem Blue Cross Prudent Buyer	800-227-3641	www.anthem.com/ca
BlueCard	800-810-2583 (800-810-BLUE)	www.bcbs.com
Delta Dental	800-765-6003	www.deltadentalins.com
Uprise Health	866-268-2510	https://hmc.personaladvantage.com (Access Code: SCDBF)
Kaiser	800-464-4000	www.kp.org
OptumRx	800-788-7871	www.optumrx.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, 2024

ELIGIBILITY RULES	
ESTABLISHING ELIGIBILITY & COVERAGE COMMENCEMENT	
All Employees	If you work an average of 23 or more hours/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. 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. 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. If your spouse is eligible for medical, prescription drug, dental, and/or vision benefits through his or her employer but fails to enroll, this Plan will pay only 40% of its normal benefits (i.e., this Plan will reduce its payment amount by 60%) under the Indemnity Medical Plan, Prescription Drug Plan, and/or Indemnity Dental Plan. This rule does not apply if both spouses are eligible for coverage as Employees of contributing Employers and one spouse has elected coverage for "Employee plus spouse or Domestic Partner." Please contact the Fund Office for more information.

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

HOW THE MEDICAL PLANS WORK
DEFINITIONS

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2024

HOW THE MEDICAL PLANS WORK	
"Allowed Amount"	The amount the Fund determines to be an appropriate payment for the Medically Necessary service(s) rendered 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 the PPO Provider (Prudent Buyer Network, the BlueCard Program, Uprise Health) has agreed by contract to accept for services provided.
"Covered Charges"	The amount determined by Kaiser and UnitedHealthcare for covered services.
INDEMNITY MEDICAL PLAN	
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. 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. When Preauthorization or Utilization Review is required, your doctor or hospital must contact Prudent Buyer/BlueCard at 800-274-7767. Anthem PPO providers will do this automatically for you. You should confirm that your other providers, including non-PPO hospitals, have done this. For mental health and substance use disorder treatment, your PPO is the **Uprise Health ("Uprise")** network. Coverage is administered by Uprise. Before receiving treatment, contact Uprise at 866-268- 2510. Preauthorization by Uprise is required for all inpatient treatments (except emergency hospitalization), intensive outpatient programs, partial hospitalization, ECT, psychological testing, and neuropsychological testing.
Services by PPO Providers	For most office visits, you must pay a $10 copay/visit. Then the Plan pays 100% of Contract Rates. 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.
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. You are responsible for any remaining balance after the allowed Basic and Major Medical benefits are paid. **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)

HOW THE MEDICAL PLANS WORK	
	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 5. *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*.
KAISER	
Provider Network	You must use **Kaiser** providers. Services rendered by non-Kaiser providers are not covered, except in an emergency. **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 5. *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	Covered 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. See Kaiser's EOC for further details. If there is a conflict between any benefit description in this Summary and Kaiser's EOC, the Kaiser EOC will control.
UNITEDHEALTHCARE	
Provider Network	You must use **UHC** providers in the **SignatureValue (SV) Advantage** 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 5. 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.
How the plan works	Covered 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. See UHC's EOC for further details. If there is a conflict between any benefit description in this Summary and UHC's EOC, the UHC EOC will control.

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2024

MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
CALENDAR YEAR DEDUCTIBLE, OUT-OF-POCKET (OOP) MAXIMUM, PREAUTHORIZATION and UTILIZATION REVIEW, AND NSA CLAIMS				
Calendar Year Deductible ("Deductible")	None	$50/person/calendar year before Major Medical pays.	None	None
Calendar Year Out-of-Pocket (OOP) Maximum	None	None	$1,500/individual, $3,000/family	$800/individual, $2,400/family
Preauthorization and Utilization Review	When Preauthorization or Utilization Review is required, your doctor or hospital must contact Prudent Buyer/BlueCard, at 800-274-7767 (in California) or 800-810-BLUE (outside California). Anthem PPO providers will do this automatically. You should confirm with non-PPO providers that Preauthorization is obtained.		See Kaiser's EOC or call Kaiser for information	See UHC's EOC or call UHC for information
Claims Subject to the No Surprises Act ("NSA Claims") – Generally applicable to claims for non-PPO Emergency Services, certain non-emergency services by non-PPO providers at PPO facilities, and non-PPO air ambulance services.	Not applicable.	Your cost sharing is determined as if the service was furnished by a PPO (In Network) provider. The Allowed Amount is determined in accordance with federal law. You cannot be balance billed.	Treated as though the services had been furnished by a Kaiser provider. You cannot be balance billed. See Kaiser's EOC or call Kaiser for more information.	Treated as though the services had been furnished by an in-network provider. You cannot be balance billed. 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/disability, including ICU and childbirth. After 120 days, Plan pays 80% of Contract Rates.	Plan pays 50% of Allowed Amount, up to 120 days/disability, including ICU only (excludes childbirth). After 120 days, Plan pays 80% of Allowed Amount. Prudent Buyer/BlueCard must Preauthorize all hospital admissions, except for childbirth or emergency hospitalizations. You must notify Anthem within 72 hours of an	100% covered	100% covered

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

MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
		emergency admission. Benefits will be reduced if you fail to obtain required Preauthorization. Unauthorized days are not covered.		
Hospital Outpatient Charges	Plan pays 100% of Contract Rates	Plan pays 85% of 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/disability. The number of allowed days is 120 days minus the number of days spent in the hospital. 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. 100% covered, limited to 100 days/benefit period.	As prescribed at designated facilities. 100% covered, limited to 100 days/calendar year from the first treatment/disability.
Emergency Room (Facility only, Physician charges are covered under Physician Hospital Visits)	Plan pays 100% of Contract Rates	Plan pays 100% of Allowed Amount. For non-Emergencies, Plan pays 85% of Allowed Amount for accident or 68% of 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.			
Outpatient Surgical Centers	Plan pays 100% of Contract Rates	Plan pays a maximum of $350/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

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2024

MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
Physician Hospital Visits	Plan pays 100% of Contract Rates	Basic Medical pays up to $25.50/day. Major Medical pays 80% of the remaining Allowed Amount after Deductible.	100% covered	100% covered
PROFESSIONAL SERVICES				
Office Visits	$10 copay/visit	Basic Medical pays up to $25.50/visit, up to a maximum of $300/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 LiveHealth Online	Not available	100% covered	100% covered
Preventive Care Services	Plan pays 100% of Contract Rates.	After the Deductible, Plan pays 85% of the Allowed Amount.	100% covered	100% covered
	Coverage is provided in accordance with the Fund's Preventive Care Guidelines. Breast pumps must be obtained through a PPO Durable Medical Equipment vendor, otherwise there is no coverage.			
Specialist Office Visits	$10 copay/visit	Basic Medical pays up to $60/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 pays according to a schedule of charges. Excess charges after Basic Medical and Deductible are covered under Major Medical at 80% of Allowed Amount.	100% covered	100% covered

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MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
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/visit and no Major Medical is payable.	100% covered	100% covered
Speech Therapy Visits	$10 copay/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/visit, up to a maximum of $300/calendar year. Major Medical pays 80% of the remaining Allowed Amount after Deductible.	100% covered	100% covered
	Subject to Utilization Review by Prudent Buyer/BlueCard.			
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 Deductible. Plan pays a $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.		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/accident or/calendar year for all illnesses. Major Medical pays 75% of the remaining Allowed Amount after Deductible.	100% covered	100% covered
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

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MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
Podiatry	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/calendar year.	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
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.		
Organ and Tissue Transplants	Covered only if transplant is performed at an Anthem-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.
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/calendar year	100% covered, up to 100 visits/calendar year
	Coverage is provided for Registered Nurse expenses or licensed vocational nurse when prescribed by a physician. 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.			

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2024

MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
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			
Additional Accidental Injury Benefit	In addition to other Plan benefits, Plan pays a maximum of $300 in Contract Rates/Allowed Amounts for Medically Necessary services and supplies incurred within 90 days of an accident as a result of the accident.		None	None
MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS				
Provider Network	Coverage is administered by **Uprise Health**. Before receiving treatments, contact Uprise at 866-268-2510. Preauthorization by Uprise 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 provided through UHC. Participants must use UHC facilities and providers.
Mental Health Inpatient	Plan pays 100% of 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 After 5th visit: $10 copay/ visit; other services at 100% of Contract Rates.	Plan pays $25.50/visit, then 80% of the remaining Allowed Amount.	100% covered	100% covered
Substance Use Disorder Inpatient	Detoxification, Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program: Plan pays 100% of 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.	Detoxification: 100% covered.	100% covered
Substance Use Disorder Outpatient	Plan pays 100% of Contract Rates	Plan pays $25.50/visit then 80% of the remaining Allowed Amount	100% covered	100% covered

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE PLATINUM PLUS PLAN – JANUARY 1, 2024

MEDICAL BENEFITS				
	INDEMNITY MEDICAL PLAN		KAISER	UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)		
MEDICAL SUPPLIES AND EQUIPMENT				
Outpatient Medical & Surgical Supplies	Plan pays 100% of Contract Rates	Basic Medical pays up to $21.25/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 (DME)	Plan pays 80% of Contract Rates	Plan pays 80% of Allowed Amount	100% covered during a stay in a hospital or Skilled Nursing Facility. DME for home use is generally covered in accordance with Kaiser's DME formulary guidelines.	100% covered during a stay in a hospital or Skilled Nursing Facility
VISION BENEFITS				
Pediatric Vision Care (up to age 19)	Routine eye exams are covered at 100%, up to $135/exam. However, amounts paid for routine eye exams will reduce the annual frame and lens benefit. A $135 maximum benefit for frames and lenses each calendar year.		Kaiser pays 100% for routine eye exams The Fund provides a $135 maximum benefit for frames and lenses each calendar year. If you go outside your HMO for routine eye exams, the Fund will pay 100%, up to $135/exam. However, amounts paid by the Fund for eye exams will reduce the $135 annual frame and lens benefit.	UHC pays 100% for routine eye exams
Adult Vision Care (age 19 and over)	A $135 maximum benefit for routine eye exams and/or frames and lenses each calendar year		Kaiser pays 100% for routine eye exams. A $135 maximum benefit for eye exams not obtained at Kaiser and/or frames and lenses each calendar year.	UHC pays 100% for routine eye exams. A $135 maximum benefit for eye exams not obtained at UHC and/or frames and lenses each calendar year.
	Note: You are permitted to opt-out of vision coverage for yourself and your Dependents Contact the Fund Office for more information.			

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND

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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 "Participating Pharmacy Directory" at www.ufcwdrugtrust.org,"Documents & Forms", and "Medical/Prescription" under "Documents")			Must use Kaiser pharmacies
Out-of-Pocket Maximum	None			
Maximum Days Supply	30 days supply/prescription. For maintenance medications, a 90-day supply may be obtained. Log into your account at www.OptumRx.com for the list of Maintenance Medications.			100 days supply/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/prescription			$5 copay/prescription
Brand	$5 copay/prescription if no generic equivalent is available. $8 copay/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/prescription
Self-administered Injectables	Plan pays 80% of OptumRx's Contract Rate. Authorization required through OptumRx. **For UHC enrollees**: Injectables that are prescribed by UHC physicians and provided by UHC are covered at 100% by the UHC plan and are not covered under the Prescription Drug Plan.			$5 copay/prescription

DENTAL BENEFITS		
	INDEMNITY DENTAL PLAN	UNITED CONCORDIA
Choice of Provider	You may select any dentist of your choice. Use Delta Dental PPO dentists to lower your out-of-pocket expenses.	You must use the United Concordia dental office in which you are enrolled
Calendar Year Deductible	$50/person; $150/family. Not applicable to routine preventative and diagnostic procedures.	None

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DENTAL BENEFITS		
	INDEMNITY DENTAL PLAN	UNITED CONCORDIA
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 Dental Schedule. For Delta Premier dentists, the Plan pays the lesser of the Delta Premier Filed Fees or the amount listed in the Dental Schedule. For non-Delta Dental dentists, the Plan pays the lesser of the amount billed by the dentist or the amount listed in the Dental Schedule. The Dental Schedule is established by the Trustees and updated annually (see "2024 Platinum Plus Indemnity Dental Schedule" at ufcwdrugtrust.org, "Documents & Forms" and "Dental" under "Documents").	See United Concordia's Schedule of Benefits
Annual Maximum Benefit	$1,800/person/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.
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

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

PLAN EXCLUSIONS	
INDEMNITY MEDICAL PLAN	
Excluded Services	The Plan does not pay benefits for the following: ○ Charges in excess of Contract Rates or, as applicable, the Allowed Amount; ○ Replacement of artificial eyes; ○ Orthognathic surgery; ○ 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); ○ Charges made by relatives of anyone in the participant's household, except for covered charges which constitute out-of-pocket expenses to such providers; ○ Experimental treatment, procedures, and therapies and any complications arising from such treatment; ○ Custodial care regardless of the type of facility and/or provider; ○ Eye examinations (including refractions and fitting of glasses), hearing aids, health aids, artificial limbs, and orthopedic appliances, except as specifically covered; ○ 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 arising out of or incurred in the course of employment, including self-employment; ○ Penile prosthesis unless preauthorized by Anthem Blue Cross; ○ Pregnancy expenses of dependent children or expenses for conditions arising from pregnancy of dependent children, except preventive care expenses; ○ Surgical correction of refractive problems, including radial keratotomy, unless vision cannot be corrected through eyeglasses or contact lenses; ○ Expenses incurred for any condition where there exists no injury or sickness, except that this exclusion does not apply to benefits specifically provided, such as hospice care, sterilization procedures, and preventive care benefits; ○ Speech therapy, except from a PPO provider; ○ Take home drugs when discharged from the hospital;

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PLAN EXCLUSIONS	
INDEMNITY MEDICAL PLAN	
Excluded Services	○ Expenses incurred by a transplant donor who is not eligible under the Plan (except for benefits specifically provided); ○ Organ or tissue transplants performed at a facility that is not an Anthem Blue Cross Center of Expertise; ○ Expenses incurred by an organ or tissue donor when the transplant recipient is not a Plan participant. ○ Vocational testing, evaluation, and counseling; ○ Injuries resulting from any form of warfare or invasion; ○ Claims filed more than one year after the date on which services were incurred; and ○ 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)
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.