

United Food & Commercial Workers Unions and Food Employers Benefit Fund

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PLAN B PLATINUM PLUS (with HMO) BENEFITS CHART – EFFECTIVE JANUARY 1, 2011

Benefits For Plan B Employees Hired Prior to October 4, 2004.

Medical Benefits

THE INDEMNITY PPO MEDICAL PLAN			
Health Reimbursement Account (HRA) TO BE USED ONLY FOR PRESCRIPTION DRUG COPAYMENTS AND COVERED MEDICAL PLAN DEDUCTIBLE AND PARTICIPANT COINSURANCE AMOUNTS, EXCLUDING PENALTIES AND DISINCENTIVES.			
Funding Per Calendar Year	\$525 for employee only, \$925 for employee with dependents. Funds not used are carried over to subsequent year.		
Health Risk Questionnaire (HRQ) Incentive Per Calendar Year	\$200 for employee only; \$250 for employee and spouse/domestic partner. Completion of the HRQ required. Funds not used are carried over to subsequent year.		
Indemnity PPO Medical Plan Benefits (HRA FUNDS CAN BE USED FOR DEDUCTIBLE AND PARTICIPANT COINSURANCE ON COVERED MEDICAL EXPENSES; HRA FUNDS CANNOT BE USED FOR CHARGES ABOVE UCR.)			
	IN-NETWORK (PPO)	OUT-OF-AREA	OUT-OF-NETWORK (NON-PPO)
Lifetime Maximum	\$2 million per person; does not include benefits paid for prescription, vision, dental and orthodontic services or amounts paid from HRA.		
Covered Charges	In-network contract rate for applicable network (Anthem Blue Cross Prudent Buyer PPO, HMC/APS or PPOC).	UCR Charges Participant is responsible for amounts over UCR not payable from HRA funds.	UCR Charges Participant is responsible for amounts over UCR not payable from HRA funds.
Annual Deductible	\$1,000 per person, \$2,000 per family.		\$1,200 per person, \$2,400 per family.
Annual Out-of-Pocket Maximum	\$2,000 per person, \$4,000 per family.		\$10,000 per person, \$20,000 per family.
Plan Coinsurance	75%	75%	50%
Participant Coinsurance	25%	25%	50%
Preventive Care	No deductible, Plan pays 100%.		After deductible, Plan pays 50%.
Covered Services	Refer to Plan's Preventive Care Guidelines for the list of covered services.		
Limitations	Refer to Plan's Preventive Care Guidelines for age and frequency.		
Emergency Care	After deductible, Plan pays 75%.		
Covered Services	Emergency room, urgent care facility, ambulance.		
Additional Accident Benefit	\$400 for covered services rendered within 90 days of the accident. Plan will use accident benefit to reimburse deductible or out-of-pocket amounts before using available HRA funds.		
Acupuncture/Chiropractic	After deductible, Plan pays 75% of scheduled allowance, up to \$1,000 per calendar year.		
Covered Services	Office visits, manipulations, modalities, x-rays, laboratory services and referrals by the chiropractor.		
Limitations	Only those services listed in the Schedule of Allowances are covered.		

PLAN B PLATINUM PLUS – Benefits For Plan B Employees Hired Prior to October 4, 2004.

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	IN-NETWORK (PPO)	OUT-OF-AREA	OUT-OF-NETWORK (NON-PPO)
Hospital Services	After deductible, Plan pays 75%.		After deductible, Plan pays 50%.
Covered Services	Inpatient Services. Skilled Nursing Facility (benefit for room and board at non-PPO or out-of-area facility is limited to 50% of the semi-private room rate at the hospital from which patient was discharged). Alternative Birthing Center. Outpatient Surgery.		
Precertification	Automatically processed by provider.	20% reduction for non-compliance. Cannot be paid from HRA funds.	20% reduction for non-compliance. Cannot be paid from HRA funds.
Professional Services	After deductible, Plan pays 75%.		After deductible, Plan pays 50%.
Covered Services	Physician office/home/hospital visits. Surgeon. Assistant Surgeon. Anesthetist. Standby Physician. Midwife. Chemotherapy & Radiation. Physical/Speech/Inhalation therapy. Cardiac/Pulmonary Rehabilitation. Home Health Care/Case Management. Organ Transplant. Hemodialysis. Mastectomy/Breast Reconstruction. Registered Nurse Services/Home Nursing. Orthoptics. Lab & X-ray.		
Limitations	TMJ surgical benefit limited to \$2,100 maximum per period of disability for non-PPO. Registered Nurse Services/Home Nursing limited to \$525,000 lifetime maximum per person.		
Other Services	After deductible, Plan pays 75%.		After deductible, Plan pays 50%.
Family Planning	All FDA-approved birth control drugs and devices, excluding oral contraceptives. No benefit for other drug or device during the effective period when one type is in use.		
Medical Supplies, Equipment, Drugs (except outpatient prescriptions)	Medical equipment and supplies such as durable medical equipment, oxygen and its administration, blood and blood products and their administration, medical prosthetics, splints, casts, crutches and other supplies, chemotherapy/ radiation/ antigens/ infusion drugs and injectable drugs (except insulin, which is covered as other prescription drugs).		
Limitations	Glucose Home Monitor – one device every two years. Mastectomy Prosthesis – \$235 annual maximum; Orthopedic Shoes – \$235 annual maximum; Colostomy Supplies – \$945 annual maximum; Orthotics – \$160 annual maximum; Hearing Aids – \$475 maximum for one aid or \$785 maximum for two aids during any three-year period; Health Aids – \$120 annual maximum.		
Podiatry Services	After deductible, Plan pays 75%.		NOT COVERED.
Limitations	Services must be authorized by Podiatry Plan of California (PPOC) and rendered by PPOC participating providers.		Contact PPOC if you need podiatric care at 800-367-7762.
Covered Services	Physician office/home/hospital visits, Surgeon.		
EMAP Services	After deductible, Plan pays 75%.		NOT COVERED.
Limitations	Services must be authorized by HMC/APS and rendered by HMC/APS participating providers.		Contact HMC/APS if you need EMAP services at 800-461-9179.
Inpatient Mental Health	Maximum 60 days of inpatient care per calendar year, up to 120 days per lifetime.		
Outpatient Mental Health	Maximum 30 visits per calendar year combined with outpatient chemical dependency.		
Inpatient Chemical Dependency	\$25,000 lifetime maximum per person combined with outpatient chemical dependency.		
Outpatient Chemical Dependency	Maximum 30 visits per calendar year combined with outpatient mental health. \$25,000 lifetime maximum per person combined with inpatient chemical dependency.		

PLAN B PLATINUM PLUS – Benefits For Plan B Employees Hired Prior to October 4, 2004.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)*		
HMO Medical Benefits (HMO Participants are not eligible for Health Reimbursement Account funding or Health Risk Questionnaire incentives.)		
	KAISER	PACIFICARE
Lifetime Maximum	None.	None.
Covered Charges	Only services received from HMO providers are covered except in emergency situations.	
Annual Deductible	None.	None.
Annual Out-of-Pocket Maximum	\$1,500 per person, \$3,000 per family.	\$1,500 per person, \$3,000 per family.
Office Visits/Professional Services	\$25 copay per visit.	\$25 copay per visit.
Emergency Room Visits	\$100 copay per visit.	\$100 copay per visit.
Hospital Services	\$250 copay per admission.	\$250 copay per admission.
Other Services	Family planning, preventive care, podiatric care, medical equipment and supplies, and hearing aids are provided through the HMO.	
Injectables (except insulin)	Provided through the HMOs. If not covered by the HMOs, paid by the Fund at 75%. After \$2,500 out-of-pocket maximum per person per calendar year, paid at 100%.	
Acupuncture/Chiropractic	Plan pays 100% of the scheduled allowance after \$25 copay for office visits, or 75% of scheduled allowance for x-ray/lab. Only those services listed in the Schedule of Allowances are covered. \$1,000 annual maximum combined for all services.	
Mental Health and Chemical Dependency	Provided through Kaiser.	<p>Provided through EMAP administered by HMC/APS.</p> <p>Outpatient visits: plan pays 100% of HMC/APS contracted rates after \$25 copay (\$12.50 copay for group sessions) up to 30-visit annual maximum.</p> <p>Inpatient care: plan pays 75% of HMC/APS contracted rate after \$250 copay per admission. After \$2,500 annual out-of-pocket maximum is met, plan pays at 100%. For mental health annual maximum is 60 days (120 days per lifetime).</p> <p>Chemical dependency treatment is limited to \$25,000 maximum per lifetime (inpatient and outpatient combined).</p> <p>Treatment of AB88 illnesses covered as any other illness and limits on days or visits do not apply.</p>

* Refer to each HMO's booklets for coverage details.

PLAN B PLATINUM PLUS – Benefits For Plan B Employees Hired Prior to October 4, 2004.

Vision Benefits*

Exam and Materials	Up to \$125 per person per calendar year.
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* Indemnity PPO Medical Plan HRA funds cannot be used for Vision expenses.

Prescription Drug Benefits*

	Maximum Days of Supply	
	30-day supply per prescription	90-day supply per prescription
Annual Deductible	None.	
Available Pharmacies	Any UFCW Participating Network Pharmacy.	Prescription Solutions home delivery service or a network pharmacy**.
Formulary Generic	\$10 copay.	\$20 copay.
Formulary Brand	\$25 copay.	\$50 copay.
Non-Formulary Drugs	\$40 copay.	\$80 copay.
Special Therapeutic Classes	For maintenance medication to treat the following conditions: hypertension, high cholesterol, diabetes control drugs (including related supplies), asthma (including related supplies), osteoporosis, glaucoma, you pay the following reduced copayments:	
Formulary Generic	\$7 copay for maintenance drugs.	\$14 copay for maintenance drugs.
Formulary Brand	\$15 copay for maintenance drugs.	\$30 copay for maintenance drugs.
Non-Formulary Drugs	\$25 copay for maintenance drugs.	\$50 copay for maintenance drugs.
Participant Submitted Claims	Available only for emergencies and out-of-area users. Lesser of purchase price or AWP less applicable copay. Amounts over AWP cannot be paid from HRA funds.	

* Indemnity PPO Medical Plan HRA funds can be used for copays only.

** If you have a prescription for a maintenance medication you may also purchase this at your local network pharmacy that has joined the 90-day maintenance program. Check with your pharmacy to see if it participates in this program.

PLAN B PLATINUM PLUS – Benefits For Plan B Employees Hired Prior to October 4, 2004.

Dental Benefits*

	Indemnity	Prepaid Clinics
Annual Deductible	\$50 per person, \$150 per family; waived for preventive and diagnostic procedures.	None.
Annual Benefit Maximum	\$1,250 per person.	None.
Definition of Schedule of Allowances	A list of services that are covered under the Indemnity and Prepaid Dental programs. Services not listed in the schedule are not covered; the participant is responsible for the cost of all such services.	
Plan Payment	Preventive/Diagnostic: 100% of scheduled allowances. Basic Restorative: 80% of scheduled allowances. Major Restorative: 70% of scheduled allowances.	100% after required participant copayments. Copayments: crown/pontics \$75; prosthodontics \$100; endodontics \$45 anterior, \$90 bicuspid, \$125 molar. Participant is responsible for services not on Schedule of Allowances.

* Indemnity PPO Medical Plan HRA funds cannot be used for Dental expenses.

Orthodontic Benefits*

	Indemnity	Panel Program
Plan Payment	75% of UCR.	100% of negotiated rate.
Benefit Maximum	\$1,500 per person lifetime.	\$1,500 per person lifetime.
Participant Responsibility	Balance of Provider's fee for service after plan payment.	\$1,200 per person**.

* Indemnity PPO Medical Plan HRA funds cannot be used for Orthodontic expenses.

**Patients who obtain care through a panel orthodontist are also responsible for: the cost of special diagnostic records in excess of the Plan's allowance, lost or broken appliance(s), missed appointments or cancellations made without 24 hour notice, cost of treatment obtained elsewhere should patient not cooperate with panel orthodontist and cost of treatment that extends past 30 months due to the patient's failure to cooperate with panel orthodontist.

Plan Contact Information

Anthem Blue Cross	800-688-3828	HMC/APS (EMAP)	800-461-9179
Kaiser HMO	800-464-4000	Prescription Solutions	800-797-9791
Pacificare HMO	800-624-8822	Prescription Solutions Home Delivery Service	800-562-6223
PPOC (Podiatry Plan)	800-367-7762	UFCW Benefit Fund	714-220-2297, 562-408-2715, or 877-284-2320

PLAN B PLATINUM PLUS – Benefits For Plan B Employees Hired Prior to October 4, 2004.

Death Benefit

Employee Death Benefit	Dependent Death Benefit	Burial Expense**
\$11,250 – \$22,500 Depending on years* of service, as follows: <ul style="list-style-type: none"> ▪ Up to 6 years \$11,250 ▪ 6 but less than 7 years \$13,500 ▪ 7 but less than 8 years \$15,750 ▪ 8 but less than 9 years \$18,000 ▪ 9 but less than 10 years \$20,250 ▪ 10 or more years \$22,500 	\$3,000	\$2,250 (Employee Only)

*Years of Service without a Break in Service (BIS) of 12 consecutive months or longer with no work in Covered Employment. A BIS results in the loss of all prior Years of Service. Contact the Fund Office for types of excused absence that stay a BIS.

**If there is no eligible beneficiary, in lieu of the Death Benefit the Fund shall pay the person who presents evidence of payment of burial expenses for the Eligible Employee the amount of such expense, up to the maximum Burial Expense benefit. Eligible Burial Expenses include: expenses of funeral home, embalming or other preparation for burial; transportation to the gravesite; purchase of the gravesite; burial costs; burial service flowers; and cost of religious services. Pre-need burial costs paid for by the Eligible Employee are not included in the definition of Eligible Burial Expenses.

Accidental Death and Dismemberment Percentages if bodily injury is effected solely through external, violent and accidental means and results in any of the below losses within 90 days after the date of the accident causing the loss.

One member (eyesight, hand, or foot)	50%
Two or more members, or loss of life	100%

EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to Medical, EMAP, Vision and Prescription Drug benefits. In addition, each coverage has specific exclusions and limitations.

GENERAL EXCLUSIONS AND LIMITATIONS

The Benefit Fund does not pay benefits for the following:

- Services or supplies that are not Medically Necessary
- Experimental or Investigative services, supplies, procedures, treatments or drugs
- Expenses directly related to a non-covered procedure, service, treatment, supply or drug
- Services provided by an immediate relative of an eligible Participant or by members of a Participant's household, except for covered expenses that are out-of-pocket expenses to the providers (The term "immediate relative" means spouse, child, parent, sibling, parent of current spouse, or grandparent.)
- Conditions covered by Workers' Compensation or arising out of or in the course of any employment or self-employment
- Injuries resulting from any form of warfare or invasion or while on active duty with the armed forces
- Charges incurred while the patient's coverage is not in effect
- Services or supplies for which there is no charge or liability to pay
- Services or supplies furnished by or for the United States government or any other government, unless payment is legally required
- Any portion of expenses provided under any governmental program or law under which the individual is or could be covered
- Any service or supply furnished by a Hospital or facility run by the federal government or other authorized agency, or at the expense of such agency or facility, except as required by federal law
- Charges in excess of Covered Charges (for example, charges that exceed Plan allowances or Usual, Customary and Reasonable limits)
- Claims submitted more than one year after the date a Covered Charge is incurred

Third Party Liability benefits must be assigned to the Fund, but not to exceed the amount payable by the Fund.

INDEMNITY PPO MEDICAL PLAN

In addition to the GENERAL EXCLUSIONS AND LIMITATIONS, the Indemnity PPO Medical Plan does not pay for:

- Services or supplies not prescribed, recommended or approved by a Physician
- Services or supplies that are not Medically Necessary for the treatment of an Illness or Injury, unless specifically covered under the Plan, such as preventive medicine benefits and sterilization procedures
- Treatment of infertility, except for the initial exam and diagnostic services
- Services to reverse voluntary surgically induced infertility
- Transsexual surgery
- Personal items provided in a Hospital
- Cosmetic procedures, except surgery to repair damage caused by accidental bodily injury, breast reconstruction following a mastectomy, or restorative surgery performed during or following mutilative surgery required as a result of illness or injury
- Expenses incurred at a non-network Hospital when a Participant is a donor for an organ transplant, unless the recipient is also a Participant
- Custodial Care and homemaker services
- Vocational training
- Ambulance services for transportation only to suit the patient's or Physician's convenience
- Paramedic services when patient is not transported to a Hospital
- Podiatric treatment by a podiatrist who is not affiliated with the Podiatry Plan Organization of California
- Treatment of mental health disorders or substance abuse (these may be covered under the EMAP)
- Treatment directly on or to teeth or gums, including tumors (These may be covered under the Dental Program)
- Charges that are used to satisfy the annual deductible
- Pregnancy of a Dependent child, and any conditions arising from the pregnancy

EXCLUSIONS AND LIMITATIONS (continued)

PRESCRIPTION DRUGS

In addition to the **GENERAL EXCLUSIONS AND LIMITATIONS**, the Prescription Drug Program does not pay for:

- Prescriptions dispensed by a licensed Hospital during confinement, except for drugs dispensed by the Hospital pharmacy for “take-home” medication in emergency circumstances
- Drugs, medications or non-drug items that may be purchased without a doctor’s written prescription, except that diabetic supplies are covered
- Contraceptive devices and non-prescription contraceptive drugs or methods
- Injectable immunization agents
- Injectable drugs administered or dispensed by a Physician (or administered by a nurse), except for injectables used for chemotherapy and Depo-Provera
- Progesterone in all forms for use in the treatment of Premenstrual Syndrome (PMS)
- Drugs used to promote hair growth
- Drugs used for the treatment of infertility
- Drugs that are not Medically Necessary for the treatment of an Illness or Injury, except as specifically provided, such as for oral contraceptives
- Appliances or prosthetics (These may be covered under the Indemnity PPO Medical Plan.)
- Lost, stolen, broken or spilled supplies or prescription drugs

VISION

In addition to the **GENERAL EXCLUSIONS AND LIMITATIONS**, the Vision Care Program does not pay for:

- Nonprescription sunglasses
- Any lenses that are not corrective lenses
- Treatment of injuries or illnesses related to the eye (these may be covered under the Participant’s medical plan)

EMAP BENEFITS

All services must be authorized by HMC/APS and rendered by HMC/APS contracted providers.

In addition to the **GENERAL EXCLUSIONS AND LIMITATIONS**, the EMAP does not pay for:

- Services otherwise provided under the Indemnity PPO Medical Plan
- Court-ordered services except those that HMC/APS would have deemed clinically necessary and appropriate, were the court not involved
- Treatment of mental retardation, pervasive developmental disorders and learning disabilities
- Further treatment of a mental disorder if the patient does not show a significant clinical response to treatment (symptom reduction) within 60 days, as determined by HMC/APS

This chart summarizes the benefits of the Plan. Not all provisions, limitations and exclusions have been included. Refer to the Exclusions and Limitations section above, the Plan Document and the Summary Plan Description for additional information.