

United Food & Commercial Workers Unions
and Food Employers Benefit Fund

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PLAN B SILVER / GOLD BENEFITS CHART – EFFECTIVE JANUARY 1, 2009

The New Indemnity Plan

SILVER PLAN – Benefits for Clerk’s Helpers and Benefits for All Other Employees with Less Than 3½ Years of Employment

HEALTH REIMBURSEMENT ACCOUNT (HRA) TO BE USED ONLY FOR PRESCRIPTION PLAN COPAYMENTS AND COVERED MEDICAL PLAN DEDUCTIBLE AND PARTICIPANT COINSURANCE AMOUNTS, EXCLUDING PENALTIES AND DISINCENTIVES.	
Funding Per Calendar Year	\$500 for single employee, \$1,000 for employee with dependents. Funds not used are carried over to subsequent year.
Health Risk Questionnaire (HRQ) Incentive Per Calendar Year	\$50 for employee only; \$100 for employee and spouse/Domestic Partner. Completion of the HRQ required. Funds not used are carried over to subsequent year.

MEDICAL 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 of California Prudent Buyer, 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	\$2,500 per person, \$5,000 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	\$300 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 \$800 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.		
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 - \$125 annual maximum; Hearing Aids - \$475 maximum for one aid or \$630 maximum for two aids during any three-year period; Health Aids - \$95 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 SILVER / GOLD BENEFITS CHART – EFFECTIVE JANUARY 1, 2009

SILVER PLAN – Benefits for Clerk’s Helpers and Benefits for All Other Employees with Less Than 3½ Years of Employment

VISION (HRA funds cannot be used for Vision expenses)		
Exam and Materials	100% of UCR up to \$125 per person per calendar year.	
PRESCRIPTION DRUGS (HRA funds can be used for copays only)		
Maximum Days of Supply	30-day supply per prescription	90-day supply per prescription
Annual Deductible	None.	
Available pharmacies	Any network pharmacy	Prescription Solutions mail order pharmacy or a network pharmacy*.
Formulary Generic	Greater of \$10 copay or 10%	\$20 copay
Formulary Brand	Greater of \$30 copay or 25%	\$60 copay
Non-Formulary Drugs	Greater of \$50 copay or 50%	\$100 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. There is an additional copay of \$25 for each emergency prescription filled at a non-network pharmacy.	
	* 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 they participate in this program.	

DENTAL (HRA funds cannot be used for Dental expenses)		
	Indemnity	Prepaid Clinics
Annual Deductible	\$50 per person, \$150 per family; waived for preventive and diagnostic procedures.	None.
Annual Benefit Maximum	\$1,000 per person.	None.
Definition of Schedule of Allowances	100% of average charges.	Not applicable.
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. Patient is responsible for services not on Schedule of Allowances.

ORTHODONTIC (HRA funds cannot be used for Orthodontic expenses)		
	Indemnity	Panel Program
Plan Payment	70% of UCR.	100% of negotiated rate.
Benefit Maximum	\$1,000 per person lifetime.	\$1,000 per person lifetime.
Participant Responsibility	Balance of Provider’s fee for service after plan payment	\$1,700 per person.**

**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 Prudent Buyer	800-422-7372	Prescription Solutions	800-797-9791
HMC/APS (EMAP)	800-461-9179	Prescription Solutions Mail Service	800-562-6223
PPOC (Podiatry Plan)	800-367-7762	UFCW Trust Fund	714-220-2297 or 562-408-2715

DEATH BENEFIT	EMPLOYEE DEATH BENEFIT	DEPENDENT DEATH BENEFIT	BURIAL EXPENSE** (EMPLOYEE ONLY)
SILVER/GOLD	\$11,250 - \$22,500 Depending on years* of service, i.e., 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

*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 prevent 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%

PLAN B SILVER / GOLD BENEFITS CHART – EFFECTIVE JANUARY 1, 2009

GOLD PLAN – Benefits for Employees (except Clerk’s Helpers) with At Least 3½ Years (42 Months) of Employment

Employees except Clerk’s Helpers will be eligible for STEP-UP prescription drug, dental, and orthodontic benefits after 3.5 years of employment, starting with services rendered on or after 43rd month of employment.

HEALTH REIMBURSEMENT ACCOUNT (HRA) TO BE USED ONLY FOR PRESCRIPTION PLAN COPAYMENTS AND COVERED MEDICAL PLAN DEDUCTIBLE AND PARTICIPANT COINSURANCE AMOUNTS, EXCLUDING PENALTIES AND DISINCENTIVES.	
Funding Per Calendar Year	\$500 for single employee, \$1,000 for employee with dependents. Funds not used are carried over to subsequent year.
Health Risk Questionnaire (HRQ) Incentive Per Calendar Year	\$50 for employee only; \$100 for employee and spouse/Domestic Partner. Completion of the HRQ required. Funds not used are carried over to subsequent year.

MEDICAL BENEFITS – Please refer to the Silver Plan on Page 1.

VISION – Please refer to the Silver Plan on Page 2.

PRESCRIPTION DRUGS (HRA funds can be used for copays only)		
Maximum Days of Supply	30-day supply per prescription	90-day supply per prescription
Annual Deductible	None.	
Available pharmacies	Any network pharmacy	Prescription Solutions mail order pharmacy 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.	
	* 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 they participate in this program.	

DENTAL (HRA funds cannot be used for Dental expenses)		
	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	100% of average charges.	Not applicable.
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.

ORTHODONTIC (HRA funds cannot be used for Orthodontic expenses)		
	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.**

***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.*

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

PLAN B SILVER / GOLD BENEFITS CHART – EFFECTIVE JANUARY 1, 2009

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
<p>The Benefit Fund does not pay benefits for the following:</p> <ul style="list-style-type: none">• 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 <p>Third Party Liability benefits must be assigned to the Fund, but not to exceed the amount payable by the Fund.</p>
INDEMNITY MEDICAL
<p>In addition to the GENERAL EXCLUSIONS AND LIMITATIONS, the Indemnity Medical Plan does not pay for:</p> <ul style="list-style-type: none">• 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 <p>Pregnancy of a Dependent child, and any conditions arising from the pregnancy.</p>
PRESCRIPTION DRUGS
<p>In addition to the GENERAL EXCLUSIONS AND LIMITATIONS, the Prescription Drug Program does not pay for:</p> <ul style="list-style-type: none">• 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 Medical)• Lost, stolen, broken or spilled supplies or prescription drugs
VISION
<p>In addition to the GENERAL EXCLUSIONS AND LIMITATIONS, the Vision Care Program does not pay for:</p> <ul style="list-style-type: none">• Nonprescription sunglasses• Any lenses that are not corrective lenses <p>Treatment of injuries or illnesses related to the eye (these may be covered under the Participant's medical plan).</p>
EMAP BENEFITS
<p>All services must be authorized by HMC/APS and rendered by HMC/APS contracted providers.</p> <p>In addition to the GENERAL EXCLUSIONS AND LIMITATIONS, the EMAP does not pay for:</p> <ul style="list-style-type: none">• Services otherwise provided under the Indemnity 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 <p>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.</p>



~~~~ ACTIVE DEATH BENEFIT ~~~~

An Active employee must be enrolled in the Plans of Medical Benefits in order to be eligible for these Death Benefits.

	Basic Death Benefit (Employee)	Death Benefit (Dependents)	Burial Expense** (Employee Only)
Platinum, Platinum Plus (Plan A)	\$15,000 - \$30,000 depending on years* of service up to 6 years \$ 15,000 6 but less than 7 years \$ 18,000 7 but less than 8 years \$ 21,000 8 but less than 9 years \$ 24,000 9 but less than 10 years \$ 27,000 10 years or more \$ 30,000	\$4,000	\$3,000
Gold, Silver (Plans B, A1, A110, B110, former Plan G)	\$11,250 - \$22,500 depending on years* of service 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 years or more \$ 22,500	\$3,000	\$2,250

Accidental Death & Dismemberment Percentages (All Active Employees' Plans)

One member 50%
Two or more members 100%
Life 100%

*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. See Plan for types of excused absence that stay a BIS.

~~~~ RETIREE DEATH BENEFIT ~~~~

A Retiree must be enrolled in the Retiree Medical Plan in order to be eligible for the Basic Death or Burial Expense benefit.

	Basic Death Benefit (Retiree)	Death Benefit (Dependents)	Burial Expense** (Retiree Only)
Retirees except Plan E	\$1,000 - \$5,000 depending on retirement date and years of credited pension service	Not Provided	\$1,000
Plan E Retirees	\$1,000	Not Provided	\$1,000

** 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 or Retiree 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 gravesite; burial costs; burial service flowers; and cost of religious services. Pre-need burial costs paid for by the Eligible Employee or Retiree are not included in the definition of Eligible Burial Expenses.