Southern California
United Food & Commercial Workers Unions
and Food Employers Joint Benefit Funds Administration, LLC

# Health Care Benefit Highlights

## FOR RETIREES EXCEPT CLASS E

Effective January 1, 2016

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Esta publicación contiene información importante acerca de sus beneficios. Si usted tiene dificultad para comprender cualquier parte de esta información, o si tiene preguntas, comuníquese con su Sindicato Local o con la Oficina del Fondo al 714-220-2297, 562-408-2715, o 877-284-2320.

# About This Booklet

This booklet is a brief summary of health care benefits available to retirees through the United Food & Commercial Workers Unions and Food Employers Benefit Fund (the "Fund"). **The Plan limits benefits for certain medical services and supplies. Refer to your current *Summary of Health Care Plans for Retirees* chart for details.**

Whether you are already retired or planning to retire, this booklet and other materials you receive from the Fund can help you make enrollment and health care decisions that best meet your needs and the needs of your family. This booklet also contains information about eligibility for benefits, how to pay for your retiree health care coverage and the importance of enrolling in Medicare Part B when you become eligible.

The Fund offers health care benefits to eligible retirees and their dependents as long as the Collective Bargaining Agreement between their Employer and their Union provides for such benefits. Future Collective Bargaining Agreements or amendments by the Board of Trustees may change or even eliminate retiree benefits for current or future retirees.

**Note:** As a retiree-only plan, the Retiree Health Care Plan is not subject to the health care reform requirements under the federal Patient Protection and Affordable Care Act (ACA).

## Where to Get More Information

Please refer to your current *Summary of Health Care Plans for Retirees* chart and other materials provided by the Fund to learn more about the benefits available to retirees and their eligible dependents.

If you have questions or need more information about the benefits described in this booklet, contact the Fund Office or your Union Local. More detailed contact information is included at the end of this booklet. You will also find helpful information on the Fund's website at scufcwfunds.com.

You may contact the Fund personally by visiting its office at:

Southern California United Food & Commercial Workers Unions and Food Employers Joint Benefit Funds, LLC
6425 Katella Avenue
Cypress, CA 90630-5238

The Fund Office mailing address is:
Southern California United Food & Commercial Workers Unions and Food Employers Joint Benefit Funds, LLC
PO Box 6010
Cypress, CA 90630-0010

This is only a brief summary of the health and welfare benefits available to eligible retirees of the Southern California United Food & Commercial Workers Unions and Food Employers Joint Pension Trust Fund. Not all provisions, limitations and exclusions are included. In case of any discrepancy between this booklet and the official Plan Documents, which include Collective Bargaining Agreements, the Plan Documents will prevail. Contact the UFCW Benefit Fund Office for additional information.

# Eligibility for Retiree Health and Welfare Benefits

Benefits are available to eligible Retirees as long as the Collective Bargaining Agreement between their Employer and their Union provides for such benefits. Future Collective Bargaining Agreements, or amendments by the Board of Trustees, may change or even eliminate Retiree benefits for current or future Retirees. Retiree benefits are not the same as benefits for Active Participants.

## How Your Eligibility Is Determined

To be eligible for Retiree Health and Welfare (RHW) benefits, you must meet all the following requirements:

1. You must have been hired:
   a. before March 1, 2004 by an Employer under a Collective Bargaining Agreement that provides for RHW benefits, or
   b. after February 29, 2004, and have been employed by an Employer who has elected to provide Platinum Plus benefits for all of its Employees hired after February 29, 2004; and
2. You must have accrued at least 10 Years[1] of Benefit Credit under the Southern California United Food and Commercial Workers Unions and Food Employers Joint Pension Trust Fund; and
3. You must have satisfied one of the following requirements with regard to employment in the Retail Food Industry:
   a. You must have earned at least 10 Years[1] of Benefit Credit under the Southern California United Food & Commercial Workers Unions and Food Employers Joint Pension Trust Fund within the 15 years immediately preceding your retirement date, or
   b. You must have worked at least 345 Hours[1] in Covered Employment in each of the three years preceding your retirement date, or
   c. You must have worked at least 1,500 Hours[1] in Covered Employment within the three-year period immediately preceding your retirement date. Period(s) of disability that prevented any employment will not be included in this three-year period, provided you furnish a medical affidavit of such disability or other evidence satisfactory to the Trustees. The period of three years will be extended by any verified periods of disability which prevented your employment, not to exceed an additional three years; and
4. If you returned to Covered Employment on or after March 1, 2004, after 5 or more consecutive calendar years with no reported hours in your Pension history, you must accrue 10 Years[1] of Benefit Credit under the Pension Plan after that absence in addition to meeting the requirements of 1 and 3 above.

## When Retiree Coverage Begins

If you qualify for RHW by meeting the requirements of 1, 2, 3 and 4 above, your benefits (medical, prescription drug and vision coverage) will begin at your age 55[2], or the effective date of your retirement, whichever is later. For the purpose of eligibility for RHW benefits, a Participant who qualifies and receives a Disability Retirement is presumed to be age 65.

1 Years and hours of service under Pension Plans A-2 and/or B-2 do not count towards meeting the eligibility requirements for RHW benefits. Hours of Service earned under reciprocity agreements with other pension plans may count, however.

2 An eligible Retiree who retires on or after November 1, 1995 under the Rule of 85 (under age 60 but with enough Benefit Credits that, when combined with age, equal at least 85) qualifies for RHW benefits as of the date of retirement.

# Health Care Benefits Overview

## Medical Coverage

The Fund provides medical benefits for retirees to help cover the cost of doctors' services, hospital stays, specialists' care, other health care services, and supplies.

**Retiree medical plan options vary depending on where you live.** If you live in a Southern California area served by the HMOs offered by the Fund, medical plans available to you are:

- The Fund's Indemnity PPO Medical Plan (Medicare and non-Medicare benefits)
- Kaiser plans: Kaiser Permanente HMO (non-Medicare)/Kaiser Permanente Senior Advantage (a Medicare HMO)[1]
- UnitedHealthcare (UHC) plans: UHC SignatureValue™ Flex HMO (non Medicare)/UnitedHealthcare Medicare Advantage (a Medicare HMO)[1].

**You must live in the HMO's service area to enroll in that HMO. If you live outside a Fund-sponsored HMO service area**, the Indemnity PPO Medical Plan is the only option available to you.

To compare the major features of the medical plans available to retirees and their dependents, refer to your current *Summary of Health Care Plans for Retirees* chart.

## Vision Coverage

If you are enrolled in one of the Fund's retiree medical plan options, vision coverage is included at no additional cost.

## Dental Coverage

Dental coverage is optional. You must be enrolled in one of the Fund's retiree medical plan options to enroll in dental coverage, and additional costs apply. The Fund offers the following two dental options:

- The Indemnity Dental Plan
- The Prepaid Dental Plan.

## Additional Health Care Benefits

### Indemnity PPO Medical Plan

Retirees and dependents enrolled in the Indemnity PPO Medical Plan are automatically covered under the following additional benefit programs:

- Prescription Drug Program and the Market Priced Drug (MPD) Program through any UFCW Unions and Food Employers Participating Network Pharmacy or Mail Service
- Acupuncture and chiropractic benefits
- Podiatry through Podiatry Plan of California (PPOC)
- Employee Member Assistance Program (EMAP): Mental/behavioral health and substance abuse benefits with in-network PPO coverage through HMC HealthWorks® (HMC), an organization with a network of health care professionals that manages the treatment of mental health/behavioral health and substance abuse issues
- Vision benefits.

### HMO Plans

For retirees and dependents enrolled in an HMO, the Fund or the HMO provides the additional health care benefits shown in the chart on the following page.

1 Dependents can be enrolled only in the same plan that the retiree elects (the Indemnity PPO plan or HMO plan, e.g., Kaiser or UHC). Medicare-eligible Retirees and Medicare-eligible dependents must have Medicare Part A and Part B coverage and reside within the HMO's service area to be enrolled in a Medicare HMO.

# HMO Plans *continued*

## MEDICAL PLANS PROVIDING ADDITIONAL HEALTH CARE BENEFITS

| Additional Health Care Benefit Programs | Indemnity PPO Medical Plan | UHC Non-Medicare HMO | Kaiser Non-Medicare HMO | UHC Medicare HMO* | Kaiser Senior Advantage Medicare HMO* |
|---|---|---|---|---|---|
| Prescription Drug Program | Provided by the Fund through any UFCW Unions and Food Employers Participating Network Pharmacy or Mail Service Pharmacy | | | | Provided by Kaiser |
| Acupuncture & Chiropractic | Provided by the Fund under the Indemnity PPO Medical Plan. Some HMOs provide limited benefits. | | | | |
| Podiatry | Provided by the Fund via Podiatry Plan of California (PPOC) | Provided by UHC | Provided by Kaiser | Provided by UHC | Provided by Kaiser |
| Mental/Behavioral Health & Substance Abuse | Provided by the Fund via EMAP, administered by HMC | | Provided by Kaiser | Provided by UHC | Provided by Kaiser |
| Vision | Provided by the Fund | Provided by the Fund (HMOs may offer additional vision care benefits.) | | | |

** Benefits provided by Medicare HMOs may be limited to benefits approved by Medicare.*

# Monthly Costs

Retirees are required to pay part of the monthly cost of their health care coverage. The cost of retiree medical coverage is reviewed annually and adjusted every April 1st by the same percentage that Medicare Part B premiums increase. Your share of the cost of retiree dental coverage is reviewed every calendar year based on the estimated cost of maintaining dental plan benefits.

Each year during annual Open Enrollment (usually in November and December), the Fund announces the monthly cost for retiree dental coverage effective the following January 1st. The Fund will also notify you in advance of any changes to your cost for medical coverage that take effect the following April 1st.

The amount you pay for retiree medical coverage depends upon your and your spouse/registered domestic partner's (if any) eligibility for Medicare, and if you elect single or family coverage.

**If you don't have a spouse or domestic partner:** You pay the single rate whether or not you enroll your eligible dependent children. In other words, coverage for dependent children of a single retiree is included in the single rate.

**If you have a spouse or domestic partner:** You pay the family rate if you want to provide coverage for your eligible spouse or partner and/or your dependent children.

**Note:** The value of coverage for domestic partners and their children may be subject to income taxes. Contact the Fund Office if you need additional information.

## Authorized Pension Deductions

Your monthly payment for your share of the cost of coverage will be deducted from your pension check if you have authorized it. If your pension check is insufficient to cover the payment, or if you have not authorized a pension deduction, you will receive your entire pension check and will be required to submit payments directly to the Fund. The Fund accepts a wide variety of payment methods including checks, money orders, Visa, MasterCard, and debit cards.

You may cancel your pension deductions at any time and continue your coverage as long as you submit timely payments to the Fund.

Any required increases in your monthly payments will be automatically applied to your pension deductions or payment amounts unless you disenroll from the Plan.

To make sure your coverage continues from month-to-month, your payment must be postmarked or delivered to the Fund Office by the Due Date. The Due Date is the last day of the prior month. For example, the payment Due Date for April coverage is March 31st. If the payment is not postmarked or delivered by that Due Date, your coverage will end at midnight on March 31st.

## Late Payment and Loss of Coverage

If your payment is not postmarked or delivered to the Fund Office by the Due Date, your coverage will end at midnight on the Due Date. If payment is postmarked or delivered within 30 days following the Due Date, your coverage will be reinstated retroactive to the date it was cancelled. However, if your payment is not postmarked or delivered during this 30-day period, you cannot re-enroll until the third regular annual Open Enrollment period that follows the date your coverage ended: The Open Enrollment period that occurs during the year in which you lose coverage will be counted as the first Open Enrollment period.

### EXAMPLE

If your coverage ended March 31, 2015, you cannot re-enroll until the Open Enrollment for 2017 with coverage effective January 1, 2018.

Failure to make your required payments on time can result in a loss of coverage for up to three years. Please see page 17 for additional information on loss of coverage.

# Enrollment

## Upon Retirement

If you are eligible when you retire (see page 2), you enroll in the UFCW Unions and Food Employers Retiree Health Plan by completing an *Enrollment For Retirees* form and a *Retiree Premium Authorization* form (or the *Revocable Authorization for Payment of Retiree Health Premium* form for Pharmacists) and submitting both forms to the Fund Office. Include all required documentation of dependent eligibility listed in your enrollment form instructions (e.g., photocopies of your marriage certificate or California Certificate of Registered Domestic Partnership and birth certificates if you are enrolling new dependents).

In most locations, the Plan offers a choice of medical plans and dental plans. Information about medical plan and dental plan options begin on page 3.

- If you are single, you may elect single coverage for yourself only, or family coverage for yourself and your eligible child(ren).
- If you are married, you may elect single coverage for yourself only; family coverage for yourself and your spouse; family coverage for yourself and your eligible children; or family coverage for yourself, your spouse and your eligible child(ren).
- If you have a domestic partner, you may elect single coverage for yourself only; family coverage for yourself and your domestic partner; family coverage for yourself and your eligible children; or family coverage for yourself, your domestic partner and your eligible child(ren).
- If you enroll your eligible dependents, you must make the necessary additional payments, if any, for their coverage.

If you are married or have a domestic partner and you elect single coverage for medical plus dental coverage, your dependents will be covered for dental benefits only. They will not have medical coverage or any of the additional benefits that are included with medical coverage.

## Annual Open Enrollment

The Fund's annual Open Enrollment usually takes place in November and December for a January 1st effective date. Open Enrollment gives you the opportunity to:

- Enroll in a Fund medical plan option if you are eligible to do so
- Change from your current medical plan to a different one (if you live in an area where Fund HMOs are offered)
- Enroll in the Dental Program if you are eligible to do so
- Change your dental plan choice
- Disenroll from the Dental Program if you are enrolled
- Review and update, if necessary, the family members you may have enrolled in the Plan.

During Open Enrollment you may also disenroll from the Fund's medical coverage but, if you do, all of your health care coverage under the Fund will end on December 31st of that year. (See "If You Decline Retiree Health Care Plan Coverage" on page 8, and "Circumstances That May Result in Loss of Your Medical Coverage or Benefits" on page 17.)

To make changes in your health care coverage, complete an *Enrollment For Retirees* form and a *Retiree Premium Authorization* form (or the *Revocable Authorization for Payment of Retiree Health Premium* form for Pharmacists). Mail both forms to the Fund Office before the Open Enrollment deadline. You can also use the *Enrollment For Retirees* form to update your personal and dependent information.

During Open Enrollment you must complete an ***Enrollment for Retirees*** form and a ***Retiree Premium Authorization*** form (or the ***Revocable Authorization for Payment of Retiree Health Premium*** form for Pharmacists) if you wish to add or drop coverage for your dependents.

# Medicare Enrollment

## Medicare Part A and Part B Coverage

Whether you are enrolled in the Indemnity PPO Medical Plan or an HMO, you must enroll in both Medicare Part A and Part B as soon as you are eligible or your out-of-pocket costs will be substantially higher. This requirement to enroll applies when you turn 65 years-old and to everyone under age 65 who is eligible for Medicare due to a Social Security disability award or end-stage renal disease. If you are enrolled in an HMO, enrollment in your HMO's Medicare or Senior Plan is also required (see page 17 for additional information).

The Fund treats all retirees and their dependents who reach age 65 and become eligible for Medicare as if they are enrolled in both Part A and Part B of Medicare, whether or not they are actually enrolled in Parts A and B.

**If you are eligible but do not enroll in Medicare Part B:**

- **Indemnity PPO Medical Plan Participants:** Benefits paid under the Indemnity PPO Medical Plan are calculated as though you and your enrolled dependent(s) are covered by Medicare Part B. If you and your dependent(s) are eligible to enroll in Part B but do not, **you will be responsible for paying the expenses that Medicare would have paid, and for reimbursing the Fund** for any overpayments made on your behalf, or on behalf of any of your Part B eligible dependents.

  For example: If you had surgery, the PPO Plan would pay 75% of the Allowed Amount, after your Annual Deductible. Under Medicare, your claim would have been paid at 80% and the PPO Plan should not have paid anything. In this case, you would be responsible for reimbursing the Plan for the 75% it paid and, because you didn't enroll in Medicare Part B, you will have to pay 100% of the claim.
- **HMO Participants:** If you are enrolled in an HMO, you will be disenrolled from the HMO and the Fund will move your coverage to the Indemnity PPO Medical Plan—only after enrolling in Medicare Part B can you re-enroll in an HMO. Your benefits under the PPO plan will be calculated as though you and your enrolled dependent(s) are covered by Medicare Part B and you will have higher out-of-pocket costs (see the example above). You will also have to reimburse the Fund for the difference in cost between the Medicare HMO premium the Fund should have paid, and the higher non-Medicare HMO premium the Fund actually paid during your coverage by the HMO.

## Medicare Part D Coverage

The Fund's Prescription Drug Program — included with the Indemnity PPO Medical Plan and the UHC Medicare Advantage HMO — provides creditable Medicare Part D prescription drug coverage.

- If you are enrolled in the Indemnity PPO Medical Plan or the UHC Medicare Advantage HMO, you should not enroll in other individual Medicare Part D plans. If you sign up for another Part D Plan, your prescription drug coverage through the Fund will be automatically terminated; your PPO and HMO medical coverage will stay the same.
- If you are enrolled in Kaiser Senior Advantage you should not enroll in other individual Medicare Part D plans. If you sign up or enroll in Part D through Medicare, your Kaiser medical and drug coverage will be terminated and your coverage will be moved to the Indemnity PPO Medical Plan, but you will not have prescription drug coverage through the Fund.

## Medicare HMO Enrollment and Disenrollment

If you enroll in a Medicare HMO, you must complete the HMO enrollment form and the Fund's enrollment form. If you wish to change from one Medicare HMO to another, fill out the Fund's *Enrollment For Retirees* form and your new HMO's enrollment form. Send both forms to the Fund Office.

If you wish to disenroll from a Medicare HMO in order to enroll in the Indemnity PPO Medical Plan, you must complete the HMO's disenrollment form as well as the *Enrollment For Retirees* form. Send both forms to the Fund Office.

Call the Fund Office if you need an HMO enrollment form or disenrollment form.

## When You Can Change Plans

Until you become eligible for Medicare you can change plans:

- Once a year during Open Enrollment
- Once in a five-year period outside of Open Enrollment.

After you become eligible for Medicare, your options are different. Contact the Fund Office for more information.

## If You Decline Retiree Health Care Plan Coverage

You may decline or disenroll from the Fund's medical and dental coverage together or dental coverage alone. You cannot have dental coverage through the Fund unless you are enrolled in one of the Fund's medical options.

If you decline enrollment in the Fund's health care program for yourself and your spouse/domestic partner, you won't be able to re-enroll yourself or your spouse/domestic partner until the third annual Open Enrollment following the date you declined coverage.

Declining Retiree Health Care Plan coverage will result in a loss of the Fund's health care coverage for up to three years. Exceptions are made only if the Plan's Special Enrollment Rights apply. See "Special Enrollment Rights" on page 9, and additional information on page 17.

## If You Decline Retiree Dental Plan Coverage

**If you decline the Fund's retiree dental coverage when you retire:** You must wait until the second annual Open Enrollment after your retirement date to enroll in the Retiree Dental Plan.

**If you disenroll from retiree dental coverage during annual Open Enrollment:** You cannot re-enroll until the third Open Enrollment following the date your dental coverage ended.

* Same-sex partner, or opposite-sex partner if at least one of the opposite-sex partners is age 62 or older.

## Eligible Dependents

Dependents eligible for the Fund's health care coverage are your:

- Legally married spouse
- Domestic partner* with whom you have a Certificate of Registration of Domestic Partnership filed with the California Secretary of State
- Your or your spouse's/domestic partner's unmarried natural child, legally adopted child, stepchild or foster child (placed by a government agency or court order) who is dependent upon you for support, and is:
  - either under age 19, or under age 24 and a full-time student enrolled in an accredited educational institution; or
  - unemployable because of permanent or physical disability that began while covered under the Plan either prior to age 19, or between the ages of 19 and 24 while enrolled as a full-time student in an accredited educational institution; or
  - a child you are required to cover under a Qualified Medical Child Support Order.

**Note:** You might be responsible for paying taxes on the imputed value of the coverage being provided to a domestic partner and his or her children. Call the Fund Office if you need more information.

Remember, your dependents' eligibility depends upon your eligibility for coverage.

### Dependent Verification and Divorce Requirements

The first time you enroll a dependent, you must provide the Fund with copies of certain documents, which are listed in the instructions provided with your *Enrollment For Retirees* form. You are required to notify the Fund immediately if you get a divorce or your domestic partnership ends.

**If the Fund has paid benefits or other payments, if applicable, on behalf of your ineligible dependents (e.g., your divorced spouse or overage child), you will be required to reimburse the Fund for the full amount paid on their behalf. See page 17 for additional information.**

# Special Enrollment Rights

There are situations when you, your spouse/domestic partner, and/or your dependent child(ren) can enroll in medical coverage (or change your previous elections) through the Fund outside Open Enrollment:

- You or one of your dependents loses other group medical coverage (including COBRA, Medicaid or State Children's Health Insurance Program (CHIP) coverage)
- You acquire a new spouse/domestic partner or dependent child
- You or one of your dependents becomes eligible for Medicaid or CHIP premium assistance.

If you request a special enrollment within 120 calendar days of one of these events, your coverage will be retroactive to the date the event occurred. If you request a special enrollment after 120 days following the event but no later than the end of that year, your new coverage will take effect the first day of the month after the Fund Office receives your enrollment form. If you request a special enrollment after 120 days following the event, and after December 31 of that year, you must wait until the next Open Enrollment period to add your new dependents (i.e., you must wait up to 12 months before you can add your new dependent). If you have questions or need more information about Special Enrollment Rights, please contact the Fund Office at 714-220-2297, 562-408-2715, or 877-284-2320, extension 445 for all three numbers.

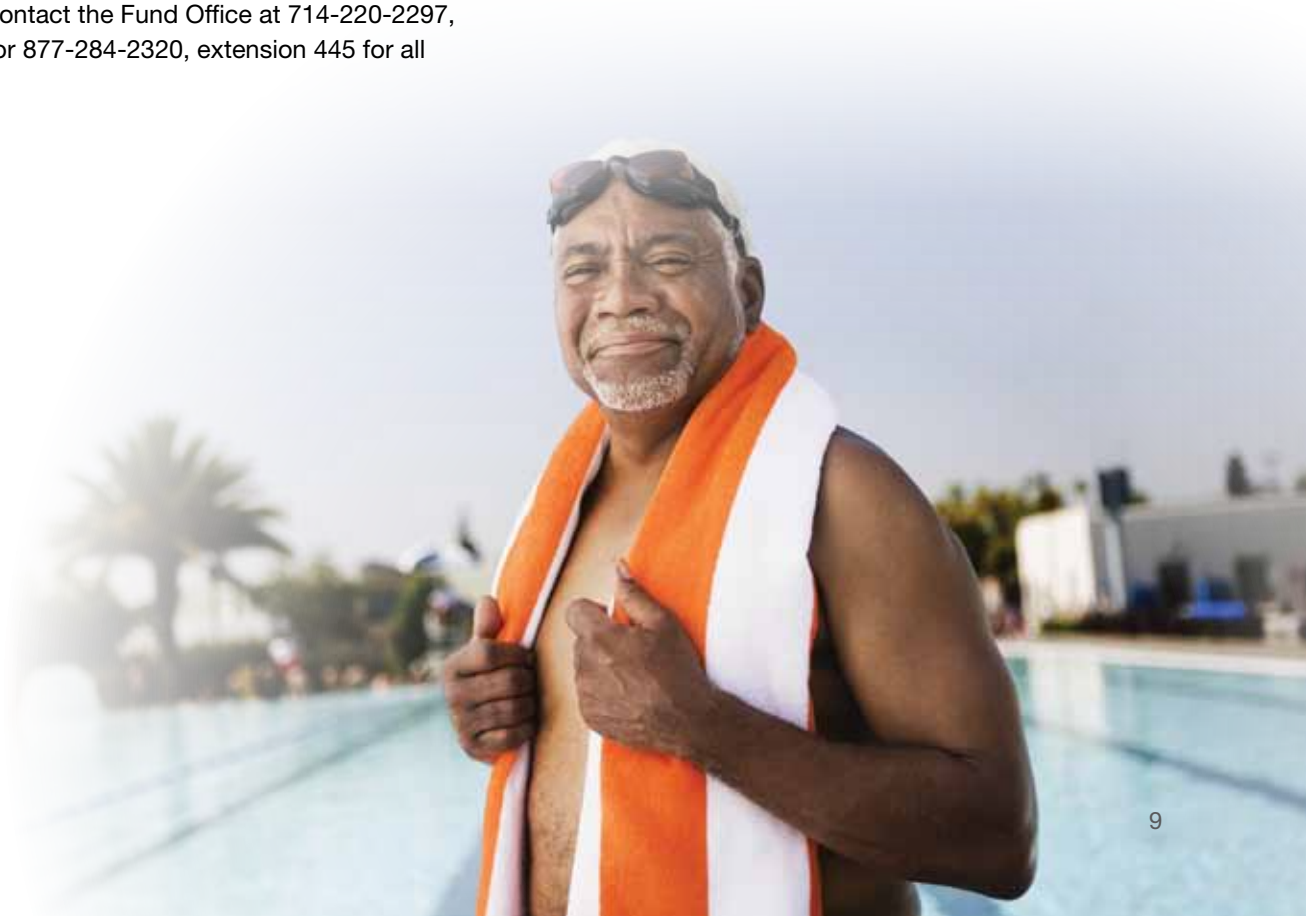
## Your HIPAA Rights

Privacy regulations issued under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) require the Fund to provide you a summary of its privacy practices, related legal duties, and your rights regarding the use and disclosure of your health care information.

A notice titled Your HIPAA Rights is available in the "About the Fund" section of the Fund's website at scufcwfunds.com. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

To obtain a paper copy of the notice from the Fund Office, please mail your request to:

UFCW Benefit Fund Privacy Officer
PO Box 6010
Cypress, CA 90630-0010



# The Indemnity PPO Medical Plan

The Indemnity PPO Medical Plan is a preferred provider organization (PPO) plan that provides up to $1,500,000 in benefits for each covered person's lifetime (reduced by up to $500,000 in lifetime benefits paid on your behalf while you were covered as an active employee by the Indemnity PPO Medical Plan). In addition to paying benefits when you and your covered family members need medical care, the Plan is designed to help prevent illness and promote wellness.

For retirees and dependents who are eligible for Medicare, Medicare is their primary coverage. The Indemnity PPO Medical Plan is not a Medicare Supplemental Plan. (See "Benefits for Medicare-Eligible Retirees and Dependents" on page 14.)

## Important Indemnity PPO Medical Plan Terms

**Allowed Amount:** The maximum amount on which payment is based for covered health care services provided to covered persons who are not eligible for Medicare. In certain instances, the Allowed Amount is also called a Covered Charge or Covered Expense. If your provider charges more than the Allowed Amount, you may have to pay the difference.

**Annual Deductible:** The amount of Covered Charges that you pay each calendar year before the Plan begins to pay its benefits.

**Annual Out-of-Pocket Maximum:** The maximum amount you have to pay for your in-network/PPO medical Coinsurance in a calendar year. After the maximum is reached, the Indemnity PPO Medical Plan will pay 100% of the cost of the individual's or family's covered medical expenses for the rest of the calendar year, up to the Plan's lifetime maximum benefit limits.

- Annual Deductibles, Copays, dental expenses, vision care expenses, prescription drug expenses, charges in excess of Allowed Amounts, and expenses that exceed benefit maximums (such as the limit for chiropractic care and acupuncture) do not count toward the Annual Out-of-Pocket Maximum.
- When you use PPO network providers, your Coinsurance counts toward your Annual Out-of-Pocket Maximum.
- In general, the Plan does not limit how much you pay out of your own pocket for services received from out-of-network (non-PPO) providers. However, if you are eligible for Out-of-Area Benefits, your Coinsurance for non-PPO provider services does count towards your Annual Out-of-Pocket Maximum.

**Coinsurance:** Your share of the cost of a covered health care service, calculated as a percentage of the Covered Charge for the service.

If you were an Indemnity PPO Participant when you retired, the Fund will use any balance remaining in your Health Reimbursement Account to pay prescription drug copays (if you submitted a *Health Reimbursement Account Rx-HRA Option Form* to the Fund Office), as well as Annual Deductibles and Coinsurance for you and your enrolled dependents. This applies to Medicare as well as non-Medicare benefits.

**Copay (or copayment):** A fixed amount ($25, for example) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. Copays do not count toward your Annual Deductible or toward your Annual Out-of-Pocket Maximum.

**Out-of-Area Benefits:** Benefits that apply to non-Medicare retirees and covered dependents who do not have access to providers in the Anthem Blue Cross Prudent Buyer PPO network or the BlueCard PPO network.

## HOW THE INDEMNITY PPO MEDICAL PLAN WORKS – NON-MEDICARE*

| When You Receive Care From PPO Providers | When You Are Not Eligible For Out-of-Area Benefits and You Receive Care from Non-PPO Providers |
|---|---|
| • The Plan covers many services, including doctors' visits, with no Annual Deductible after you pay a Copay.<br>• For most services, such as inpatient hospital care, you have to satisfy the Plan's Annual Deductible of $500 per person/$1,500 per family before the Plan pays its share of your Covered Expenses.<br>• Once you satisfy the Annual Deductible, you and the Plan share in the cost for most services through Coinsurance (75% is payable by Plan; 25% is your responsibility).<br>• Coinsurance for services from a PPO provider is a percentage of the "network contract rate" for a given service. PPO providers agree to keep their charges at or under the contracted rate.<br>• The Plan keeps track of the amount you pay in Coinsurance for PPO services. Once you reach the annual in-network $5,000 per person/$10,000 per family Annual Out-of-Pocket Maximum, the Plan pays 100% of your covered PPO charges for the rest of the calendar year, up to the Plan's lifetime maximum benefit limits. | • You first have to satisfy the Plan's non-PPO out-of-network Annual Deductible of $750 per person/$2,250 per family before the Plan starts paying any of your medical claims.<br>• Once you satisfy the Annual Deductible, you and the Plan share in the cost of most services through Coinsurance (50% is payable by Plan; 50% is your responsibility).<br>• Coinsurance for services from a non-PPO provider is a percentage of the Plan's Allowed Amount for a given service. Often a non-PPO provider's charges are higher than the Allowed Amount. In addition to your Coinsurance, you are responsible for paying amounts that exceed the Plan's Allowed Amount.<br>• There is no Out-Of-Pocket Maximum for non-PPO services and the Plan will never pay 100% of the Covered Charge. |

** Benefits may differ for retirees and dependents who are eligible for Medicare.*

You are strongly encouraged to use PPO providers. If you go out-of-network, you will pay more of your medical expenses. To find a PPO provider visit anthem.com/ca or call the applicable "Find a PPO Provider" phone number listed on page 25 of this booklet and on the back of your medical ID card.

# Important Indemnity PPO Medical Plan Rules (Non-Medicare)

**In-network (PPO) benefits maximize non-Medicare benefits** available under the Plan. The Plan's in-network Coinsurance rate is 75% versus 50% for out-of-network care. What's more, PPO doctors, hospitals and other medical service providers have agreed to charge the Fund's non-Medicare retirees and covered dependents lower, "preferred customer" contract rates. So, you save money when you receive care from PPO providers.

**All non-emergency services received from non-PPO providers are subject to a higher Annual Deductible and a 50% Coinsurance rate.**

**Precertification for non-emergency hospital and other inpatient facility admissions is required for all individuals who are not covered by Medicare.** It is automatically performed if services are received through a PPO provider: The Anthem Blue Cross PPO network or the BlueCard PPO network for medical care; and HMC HealthWorks® (HMC) for mental/behavioral health and substance abuse care. *Precertification is NOT automatic outside the PPO networks,* so be sure to let your provider know that you need to get precertification before being admitted to a hospital or other inpatient facility.

There is a 20% reduction in non-Medicare Indemnity PPO Medical Plan benefits for not complying with hospital precertification if the patient is out-of-area or at a non-PPO facility. Also, no benefits are available for treatments that are not medically necessary.

**The Plan limits benefits for certain medical services and supplies.** Refer to your current *Summary of Health Care Plans for Retirees* chart and page 17 for more information.

### Women's Health and Cancer Rights

In accordance with federal law, all of the Fund's medical plan options cover mastectomy-related services, including reconstruction and surgery to achieve symmetry, prostheses, and treatment of complications resulting from the mastectomy, including lymphedema. Regular Plan provisions, including Annual Deductibles and Coinsurance, apply.

**If you receive emergency room treatment, you must pay the emergency room Copay**, but you do not have to pay the Annual Deductible before receiving emergency room benefits from the Plan. The Copay will be waived if you are admitted to the hospital within 24 hours after your emergency room visit. Then the Plan will pay its share of your Covered Charges after you satisfy your Annual Deductible.

**There is a $1,000 maximum benefit for non-PPO surgical center services.** The Plan will pay no more than $1,000 if you receive services at an out-of-network surgical center (for example, for arthroscopy or cataract surgery). After you meet your Annual Deductible, the Plan will pay 50% of the Allowed Amount up to the $1,000 maximum. You are responsible for paying the remainder of the cost.

The chart below provides an example comparing how much you might pay when you use an in-network outpatient surgical center versus an out-of-network surgical center. The example assumes you have met your Annual Deductible but not your Annual Out-of-Pocket Maximum.

#### OUTPATIENT SURGICAL CENTER BENEFIT EXAMPLE (NON-MEDICARE)

| Cataract Surgery | When You Use an In-Network (PPO) Surgical Center | When You Use an Out-of-Network (Non-PPO) Surgical Center |
|---|---|---|
| Provider charges | $2,000 | $8,500 |
| Charges allowed by the Plan | $2,000 (Contract rate) | $4,000 (Allowed Amount) |
| Plan's Coinsurance | x 75% = $1,500 | x 50% = $2,000 |
| Final Plan payment | $1,500 | $1,000 (maximum Plan payment) |
| Your share of costs | **$500** (25% Coinsurance) | **$7,500** (All charges over $1,000) |

**Chiropractic care and acupuncture benefits cover only those services listed in the Plan's schedule of allowances.** The benefit for chiropractic care and acupuncture will be paid at a percentage of the Allowed Amount, subject to applicable Annual Deductibles. There is a per-calendar-year combined benefit maximum for these services, which includes related x-ray and lab expenses. (See page 20 for more information about chiropractic care and acupuncture benefits.)

**Employee Member Assistance Program (EMAP) benefits** for mental/behavioral health and substance abuse treatment are subject to the same Annual Deductibles, Coinsurance, and limitations that apply to medical benefits. In-network benefits are provided through HMC HealthWorks® (HMC). To receive maximum benefits from the EMAP, always call HMC at 800-461-9179 if you or any of your covered family members need mental/behavioral health care or treatment for substance abuse. (See page 18 for more about EMAP benefits.)

Non-emergency services for mental/behavioral health care or treatment for substance abuse that are provided outside the EMAP are not covered. You will be responsible for all charges.

# Non-Medicare Knee/Hip Replacement Hospital Benefit

The Benefit Fund, working with Anthem Blue Cross and HMC, provides special hospital benefits for routine knee and hip joint replacement surgeries.

## Allowed Amount for Hospital Charges

The Plan's Allowed Amount for hospital charges incurred for routine knee and hip joint replacement surgeries is $30,000. Regardless of how much a hospital charges, the Plan's payment on your behalf is based on the lesser of the hospital's charge or $30,000. Hospital charges for these surgeries typically include the cost for the hospital stay and the devices and materials needed for the replacement. The $30,000 Allowed Amount does not apply to charges from surgeons or other providers involved in your care. Separate calendar-year maximums apply for physician fees. Refer to your current *Summary of Health Care Plans for Retirees* chart for details.

## Designated Hospitals

To keep knee and hip joint replacement hospital costs within the $30,000 Allowed Amount, you have access to many well-known hospitals and surgical facilities in California. These "Designated Hospitals" are highly respected for the quality of their orthopedic surgical facilities, patient care, and cost effectiveness.

If your doctor recommends that you or any of your covered family members have a knee or hip replacement surgery, call HMC at 844-751-4530 and they will send you more detailed information about your benefit along with a current list of Designated Hospitals.

**Not All Anthem Blue Cross PPO Hospitals are Designated Hospitals!** Because your costs may be so much higher at a non-Designated Hospital, it is important to understand what you may pay before you or your covered family members have a knee or hip joint replacement surgery. If Anthem Blue Cross receives a medical claim that indicates that you or a covered family member may need a knee or hip replacement, HMC will contact you by mail and/or by phone to explain your options.

You will pay much lower out-of-pocket costs when you go to a Designated Hospital for a routine knee or hip joint replacement surgery. If your doctor recommends that you or any of your covered family members have a knee or hip replacement surgery, call HMC at 844-751-4530 and they will send you more detailed information about your benefits along with a current list of Designated Hospitals.

## How the Knee/Hip Replacement Hospital Benefit Works

**If you have your knee or hip replacement surgery at a Designated Hospital:** You will have to meet your Annual Deductible and pay your Coinsurance (25% of Covered Charges), but you will not have any out-of-pocket costs beyond your Annual Deductible and your Coinsurance. After you reach the Plan's Annual Out-of-Pocket Maximum, the Plan pays 100% of the remaining charges, up to the Plan's lifetime maximum benefit limits.

**If you have your knee or hip replacement surgery at a non-Designated Hospital:** Your out-of-pocket costs could be extremely high. After you pay your Annual Deductible and your share of Coinsurance, you must also pay any charges above the $30,000 Allowed Amount. The Plan's Annual Out-of-Pocket Maximum will not limit your share of the costs.

**If you do not live near a Designated Hospital:** If you qualify for Out-of-Area Benefits, hospital charges will be covered as they are now for any other hospitalization, and the $30,000 Allowed Amount will not apply.

## Knee/Hip Hospital Benefit Example

As the example below shows, your share of costs will be much lower when you use a Designated Hospital. Know before you go!

| | Anthem Blue Cross Designated Hospital | Anthem Blue Cross Non-Designated PPO Hospital | Out-of-Network Hospital |
|---|---|---|---|
| Hospital Charges: | $22,000 | $35,000 | $42,000 |
| Allowed Amount: | $30,000 | $30,000 | $30,000 |
| **Part One: You pay your share of the Allowed Amount (Annual Deductible and Coinsurance)** | | | |
| | **$5,500**<br>You pay your $500 Annual Deductible plus 25% Coinsurance until you reach your Annual Out-of-Pocket Maximum of $5,000 | **$7,875**<br>You pay your $500 Annual Deductible plus 25% Coinsurance on remaining Allowed Amount<br>($29,500 x 25% = $7,375) | **$15,375**<br>You pay your $750 Annual Deductible plus 50% Coinsurance on remaining Allowed Amount<br>($29,250 x 50% = $14,625) |
| **Part Two: The Plan pays the remaining share toward the Allowed Amount** | | | |
| | $16,500 | $22,125 | $14,625 |
| **Part Three: You pay all additional charges over the Allowed Amount** | | | |
| | $0 | $5,000 | $12,000 |
| **Your Out-of-Pocket Cost:** | **$5,500** | **$12,875** | **$27,375** |

## Benefits for Medicare-Eligible Retirees and Dependents

Medicare benefits differ from non-Medicare benefits in many ways, including the following:

- For professional medical services (such as doctor office visits): Medicare determines the Allowed Amount for services covered by Medicare.
- For hospital services: The Allowed Amount for services covered by Medicare is the lesser of the Medicare Allowed Amount or the Anthem Blue Cross Prudent Buyer PPO contract rate. Hospital precertification is not required.
- Medicare deductibles and coinsurance rates are different from those under the Indemnity PPO Medical Plan for non-Medicare retirees and dependents.

If you should have enrolled in Part B but did not, see pages 7 and 17.

For details about Medicare benefits refer to the current *Medicare and You* booklet, available online at medicare.gov.

## How to File a Medical Claim

When you use the Anthem Blue Cross Prudent Buyer PPO network or BlueCard PPO network, there is no need to file claim forms. Your network provider handles the paperwork.

To file a claim for out-of-network benefits under the Indemnity PPO Medical Plan, follow these steps:

- Get the itemized bills or statements from the doctor and/or hospital.
- Print your name and Social Security number or Family ID on each document and make photocopies for your records.
- Mail the itemized bills or statements to:

  **United Food & Commercial Workers Unions and Food Employers Benefit Fund**
  **PO Box 6010**
  **Cypress, California 90630-0010**
- Mail additional bills or statements for any services covered by the Plan to the Fund Office as soon as you receive them.

All claims submitted more than 12 months after the charges are incurred will be denied.

## Assignment of Benefits

Benefits for charges by Indemnity PPO Medical Plan network hospitals and other PPO network providers are paid directly to the provider of the service.

For other claims, you may request that benefits be paid directly to the provider of the service. Any benefits due that are not assigned to a provider will be paid to you.

The Plan may not honor an assignment of benefits to an out-of-network provider that has submitted excessive charges, charged for unnecessary services, or refused to provide its taxpayer identification number.

# HMO Plans—Medicare and Non-Medicare

To enroll in an HMO, you must live in its service area and you are restricted to using only that Plan's doctors and hospitals. If you use a doctor or hospital not affiliated with your HMO, your charges will not be reimbursed. Exceptions are made only for emergency care authorized by your medical group or HMO.

In general, HMOs cover most medical services at 100% after a copay. There are no deductibles or lifetime maximum dollar limits for medical care. Covered medical care includes routine preventive care and wellness programs.

If you or an enrolled dependent are eligible for Medicare and choose HMO coverage, the Fund requires that you enroll in that HMO's Medicare plan and in Medicare Part A and Part B.

HMO Plans cover many medical services at no charge or with a copay. The Fund will not reimburse you for the cost of services you receive outside your HMO or for your HMO copays or deductibles. The Fund does not coordinate benefits with HMOs.

## HMO Plan Options

- **Kaiser plans:** Kaiser Permanente HMO (non-Medicare)/Kaiser Permanente Senior Advantage (Medicare)
- **UnitedHealthcare (UHC) plans:** UHC SignatureValue™ Flex HMO (non-Medicare)/ UnitedHealthcare Medicare Advantage (Medicare).

Your covered dependents will be enrolled in the same HMO that you have. For example, if you choose Kaiser and you are on Medicare, you will be enrolled in Kaiser's Senior Advantage HMO and your non-Medicare dependents (if any) will be enrolled in the traditional Kaiser Permanente non-Medicare HMO.

Those enrolled in Kaiser Senior Advantage receive their prescription drug benefits through Kaiser. The Fund's Prescription Drug Program automatically covers retirees and dependents enrolled in a UHC HMO, or the Kaiser Permanente non-Medicare HMO. The Fund's prescription drug program is explained beginning on page 18 of this booklet and in your current *Summary of Health Care Plans for Retirees* chart.

## HMO Primary Care Physician (PCP) Requirements

A "primary care physician" is a medical doctor who will provide your care and refer you to specialists, as needed.

**Kaiser Permanente** does not require you to designate a PCP, but members must receive all their health care from Kaiser providers and facilities.

**UHC HMOs** require that you choose a PCP. If you are enrolled in a UHC HMO and go to a doctor other than your PCP without a referral from your PCP, you may be responsible for paying 100% of that doctor's charges. Refer to your HMO's *Evidence of Coverage* booklet for details.

- **UHC** requires that each enrolled family member select a PCP, but the rules for choosing a PCP are different for Medicare and non-Medicare members.

- All Medicare-eligible family members will be in the UHC Medicare Advantage HMO, and all non-Medicare family members will be in the UHC SignatureValue™ Flex HMO. Provider selection requirements differ under each of these plans, as follows:
  - **All family members in the UHC Medicare Advantage HMO** must choose a PCP from within the UHC Medicare Advantage network.
  - **All family members in the UHC SignatureValue™ Flex HMO** must be enrolled in one of the three UHC Flex networks (Network 1, Network 2, or Network 3). Each family member must select his or her own PCP from within that same network. They can change PCPs or medical groups within that network at any time. More detailed information about HMO benefits is included separately in the *Summary of Health Care Plans for Retirees* chart and each HMO's brochures.

# Coordination of Indemnity PPO Medical Benefits

## Non-Medicare Plans

The Fund follows a "non-duplication of benefits" rule. The combined amount of benefits payable by this Fund's Plan and other plans will not exceed the benefit that would have been paid had this Fund been the primary payer. Benefits paid by this Fund will not exceed the amount that would have been paid had no other plan been involved (this is referred to as the "normal benefit").

If you have coverage under two or more plans, one is the primary plan while the others are secondary plans. The primary plan pays benefits first without regard to the other plans involved. Note that under the "non-duplication of benefits" rule, the Fund will not coordinate with HMO plans regardless of which plan is considered to be the primary payer. In other words, the Fund will not reimburse HMO copays or deductibles. The determination of which plan is primary has not changed.

If this Plan is secondary and another plan is primary, then benefits will be determined as follows:

- If the primary plan's payment is less than the benefits provided under this Plan, 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 under this Plan, this Plan will not pay any additional benefits. This means you may still have some out-of-pocket expense even though two plans are involved.
- Any medical plan that has no coordination of benefits rule is automatically primary.

## Medicare Plans

For retirees and dependents eligible for Medicare, Medicare coverage is primary. The Fund follows a "non-duplication of benefits" rule. This means that the Fund will not pay benefits for amounts reimbursed by other plans, including Medicare. For example, if the Fund would have reimbursed 75% for a given service, but Medicare already paid 80%, the Fund will make no additional payments.

The Fund may, however, reimburse a portion of your Medicare deductibles and coinsurance. Also, remember that if you are enrolled in the Indemnity PPO Medical Plan or the UHC Medicare Advantage HMO, you are automatically covered under the Fund's Prescription Drug Program.

# Circumstances That May Result in Loss of Your Medical Coverage or Benefits

Your medical coverage may be affected by the following circumstances.

- Enrollment:
  - No benefits are payable for treatment you or a covered dependent receive before coverage begins or after coverage ends.
  - If you do not elect retiree medical coverage when you first retire, or if you lose your coverage in the future (e.g., disenrollment or failure to make your payments), you may not enroll until the third annual Open Enrollment following the date you declined or lost your coverage (see page 8).
  - A new dependent must be enrolled within 120 days following the date of marriage, establishment of a domestic partnership, birth, adoption, or placement for adoption. No medical benefits are payable on behalf of a dependent who is not properly enrolled under the Plan (see pages 8 and 9).
  - You must notify the Fund if a covered dependent is no longer eligible for coverage, (in the event of a divorce, for example) otherwise you will be required to reimburse the Fund for amounts paid on their behalf after he or she became ineligible (see page 8).
- Indemnity PPO Plan:
  - To receive the highest benefit under the Indemnity PPO Medical Plan, you must use in-network providers—you will have higher out-of-pocket costs if you use a non-preferred provider (see page 11).
  - If you use non-preferred providers under the Indemnity PPO Medical Plan, you must file a claim before benefits can be paid (see page 14).
  - There is a 20% reduction in PPO benefits for not complying with precertification requirements for non-emergency hospital and other inpatient facility admissions. Precertification is automatically performed by in-network providers, but not by non-preferred providers (see page 11).
  - The Plan limits benefits for certain medical services and supplies. Refer to your current *Summary of Health Care Plans for Retirees* chart for details.
- HMO Plans:
  - If you are enrolled in an HMO and receive non-emergency services from a provider that is not affiliated with your HMO, your charges will not be reimbursed (see page 15).
  - If you move outside the HMO's service area, you are not eligible for coverage by that HMO (see page 15).
  - HMOs may limit benefits for certain medical services and supplies. Refer to your current *Summary of Health Care Plans for Retirees* chart for details.
- If you or a covered family member are eligible for Medicare Part B coverage but do not enroll, you will have substantially higher out-of-pocket costs (see page 7).
- If your monthly payment for health care is not postmarked or delivered to the Fund Office by the Due Date, your coverage will be terminated at midnight on the Due Date. Your coverage will be reinstated if you make payment within the 30-day grace period immediately following the Due Date (see page 5).
- If you recover money in connection with injuries caused by a third party (for example, as the result of a lawsuit, automobile accident, etc.), the Plan is entitled to recoup the money it paid on your behalf related to such injuries. You are required to assist the Plan in recovering this money.
- The Plan has the right to recover amounts that are paid to you by mistake. For example, if a claim payment exceeds the amount allowed by the Plan, the Plan has the right to recover the excess amount from the person or facility that received it (see pages 7 and 8).

# Employee Member Assistance Program (EMAP)

The EMAP helps people enrolled in the Indemnity PPO Medical Plan or the UHC SignatureValue™ Flex HMO with problems that can adversely affect their mental health and wellbeing.

To receive maximum EMAP benefits, you must use the HMC HealthWorks (HMC) network of providers which includes psychiatrists, psychologists, marriage and family therapists, hospitals and rehab facilities. Non-emergency services for mental/behavioral health care or treatment for substance abuse that are provided outside the EMAP are not covered. You will be responsible for all charges. More information is available at hmchealthworks.com.

**Important:** All non-emergency admissions to hospitals and rehab facilities for treatment of mental/behavioral health or substance abuse issues must be pre-certified with HMC by calling 800-461-9179. If you fail to precertify non-emergency care, you may be responsible for paying 100% of incurred charges.

If you are enrolled in the Kaiser Permanente non-Medicare HMO, Kaiser Senior Advantage, or UHC Medicare Advantage, coverage for mental/behavioral health and substance abuse care is provided through your HMO. Contact your HMO for details.

# Prescription Drug Program

The Fund includes its Prescription Drug Program benefits with all of its medical plan options *except Kaiser Senior Advantage*. Kaiser Senior Advantage members must obtain their prescription drugs from Kaiser pharmacies. Please refer to your *Summary of Health Care Plans for Retirees* chart for details on the prescription drug program for Kaiser Senior Advantage.

## Participating Pharmacies

Except as noted above for Kaiser Senior Advantage members, you must use a UFCW Unions and Food Employers Participating Pharmacy or Mail Service Pharmacy to receive prescription drug benefits. Prescriptions filled at non-participating pharmacies, including HMO pharmacies, are covered only in the event of an emergency or in certain situations where a Participating Pharmacy is not available. Participating Pharmacies are located throughout the U.S. and are staffed by pharmacists covered by collective bargaining agreements with the UFCW. A list of Participating Pharmacies is available on the Fund's website at scufcwfunds.com. For information on Participating Pharmacies outside California, please call the Fund Office.

The Fund's Prescription Drug Program — included with the Indemnity PPO Medical Plan and the UnitedHealthcare Medicare Advantage HMO — provides creditable Medicare Part D prescription drug coverage. See "Medicare Part D Coverage" on page 7.

## Prescription Drug Copays

For medical plans other than Kaiser Senior Advantage: You do not have to satisfy a deductible to receive prescription drug benefits. You pay your portion of the cost of a covered prescription drug by making a copay (copayment), as described in your current *Summary of Health Care Plans for Retirees* chart.

Copays vary depending on whether the prescription is:

- A generic drug or a brand name drug
- A formulary or non-formulary drug
- A Preferred or Non-preferred Drug under the Market Priced Drug Program
- A 30-day or 90-day supply
- A long-term maintenance medication included in one of the Fund's special therapeutic classes of drugs used for treating hypertension, high cholesterol, diabetes (including related supplies), asthma (including related supplies), osteoporosis, or glaucoma
- Any other drug taken on a regular basis or for which your physician prescribes more than a 30-day supply.

## Market Priced Drug Program

The Market Priced Drug (MPD) Program applies to everyone covered under the Fund's Prescription Drug Program except those enrolled in the Fund's Disease Management Program. (Please refer to your *Summary of Health Care Plans for Retirees* chart for details on the prescription drug program for Kaiser Senior Advantage.) It is designed to help you and your doctor identify lower cost prescription drugs for treating many common health conditions. Lower cost drugs are called "Preferred Drugs" under the MPD program. Preferred and Non-preferred Drugs must meet Food and Drug Administration (FDA) standards for safety and effectiveness.

When you use a Preferred Drug to treat a condition included in the MPD Program, you will pay the applicable generic or brand copay. However, if you use a drug that is not on the Preferred Drug list (known as a "Non-preferred Drug"), your out-of-pocket cost will be much higher. You will pay the applicable brand or generic copay for the Non-preferred Drug PLUS the price difference between the Non-preferred and Preferred Drug.

The Fund's pharmacy benefits management vendor periodically reviews each Participant's prescription drug history. If you are using a Non-preferred Drug when an MPD alternative is an option for you, you will receive a personalized letter that outlines the medications affected by this program, the suggested MPD alternative, and your estimated savings from switching. The letter will also explain the process your doctor can follow if she or he believes that a change in your medication is clinically inappropriate. If the pharmacy benefits management vendor approves the exception, the standard copay shown in the Prescription Drug section of your current *Summary of Health Care Plans for Retirees* chart will apply.

For a list of Categories of Prescription Drugs Covered Under the MPD program, visit the Benefit Fund's website at scufcwfunds.com. Details about how the Market Priced Drug Program works are also posted on the Fund's website.

## UnitedHealthcare Medicare Advantage HMO Coverage for Self-injectable Medications

The UnitedHealthcare Medicare Advantage HMO does not cover self-injectable medications other than insulin. However, the Fund provides the following coverage for prescribed self-injectable medications other than insulin:

- The Fund pays 75% of the cost, and you are responsible for the remaining 25%
- You do not have to meet an annual deductible
- There is an individual annual out-of-pocket maximum for self-injectable medications of $2,500 per calendar year. This means that after you have paid $2,500 out of your own pocket for self-injectable medications in one calendar year, the Fund will pay 100% of the cost of your self-injectable medications for the remainder of that calendar year.

UnitedHealthcare Medicare Advantage HMO Participants: If you or any of your Medicare-covered dependents need to fill a prescription for a self-injectable medication other than insulin, call the Fund Office for assistance. The Fund can provide you with details about your coverage and refer you to specialty pharmacies that may fill the prescription at a reduced cost.

# Vision Care Benefits

The Fund provides vision care benefits to everyone enrolled in one of its medical plan options. The Plan pays up to $125 per person per calendar year for vision exams and materials (eyeglasses or contact lenses, for example). Benefits for corrective lenses and frames are payable as long as you get them within 12 months of the date of your vision exam.

You may receive vision care from any provider you wish. If you are enrolled in an HMO, you may be eligible for additional benefits for vision care provided by the HMO.

# Acupuncture and Chiropractic Benefits

Acupuncture and chiropractic care benefits are provided under the Indemnity PPO Medical Plan for retirees and dependents enrolled in either the Indemnity PPO Medical Plan or one of the Fund's HMOs.

Preauthorization of treatment is not required and covered individuals may obtain care from any licensed acupuncturist or licensed chiropractor they choose. However, Indemnity PPO Medical Plan members can reduce their out-of-pocket expenses by choosing providers in the Anthem Blue Cross Prudent Buyer PPO or BlueCard network.

Acupuncture and chiropractic treatment have the same Copay as any other doctor's visit, which is $25 for both Indemnity PPO Medical Plan and HMO Participants. The Plan will reimburse 100% of the Allowed Amount for covered procedures minus the Copay.

**For Indemnity PPO Medical Plan Participants**, related diagnostic testing is reimbursed at 75% of the Allowed Amount for covered procedures once the Annual Deductible has been satisfied.

**For HMO Plan Participants**, related diagnostic testing is reimbursed at 75% of the Allowed Amount for covered procedures.

There is a $500 per calendar year, per person combined maximum benefit for acupuncture services, chiropractic services, and related diagnostic testing. Once the maximum benefit is reached, you pay 100% of the cost for subsequent services and tests.

# Podiatry Benefits

Benefits for medically necessary podiatric care are available to everyone enrolled in the Indemnity PPO Medical Plan. If you are enrolled in an HMO, you must obtain your podiatric care through your HMO.

The Fund contracts with Podiatry Plan of California (PPOC) to provide all podiatry services to its Indemnity PPO Medical Plan Participants. PPOC is a statewide network of podiatrists. PPOC monitors the services rendered by its podiatrists to ensure that patients receive appropriate treatment and quality care.

Authorized PPOC treatment is subject to the same Copays, Annual Deductibles, and Coinsurance as other PPO services. You pay a $25 Copay for office visits, and other services are reimbursed at 75% after your Annual Deductible is met. Your Coinsurance is 25%.

To find a PPOC provider, call PPOC at 800-367-7762 or go to podiatryplan.com. You may also call your Union Local or the Fund Office for the name of a PPOC podiatrist near you. Services provided by podiatrists who are not part of the PPOC Network are not covered.

When making an appointment, identify yourself (or your covered dependent) as a Participant in the Indemnity PPO Medical Plan of the United Food & Commercial Workers Unions and Food Employers Benefit Fund. The PPOC podiatrist will verify your eligibility for the PPOC Podiatry Program. Your PPOC provider will bill the Fund directly.

# Dental Plan Options

Dental coverage is an optional benefit. You must be enrolled in one of the Fund's retiree medical plans to enroll in dental coverage, and additional costs apply.

The Fund offers both the Indemnity Dental Plan and the Prepaid Dental Plan to eligible retirees.

Both plans cover dental services so long as the service in question qualifies as a "Covered Procedure". Covered Procedures include preventive and diagnostic services and basic and major restorative services. No benefits are provided for services that do not meet the Fund's definition for "Covered Procedure". See your Indemnity Dental Plan SPD for description of Covered Procedures.

## Enrollment

See page 6 for details about enrolling in retiree dental coverage.

If you are a retiree and have been enrolled for the calendar year ending on December 31, your coverage will automatically continue for the following year (January 1 through December 31) unless you notify the Fund Office in writing or on your *Enrollment for Retirees* form that you wish to disenroll during Open Enrollment effective the beginning of the next calendar year. Once enrolled, you must remain enrolled for the duration of the calendar year. You may not disenroll any time during the year except during the next annual Open Enrollment.

As a Retiree, once you disenroll from the Dental Plan, you must wait until the third annual Open Enrollment after rejecting dental coverage to enroll again unless you disenrolled from both the Medical and Dental Plans and your reenrollment is approved under the Plan's "Special Enrollment Rights" provisions outlined on page 9. Contact the Fund Office if you have questions.

## Cost of Coverage

If you are a retiree who elects dental coverage, you must pay monthly for this coverage and enroll for a *full year's coverage*. During annual Open Enrollment the Fund announces the monthly cost for dental coverage effective January 1 of the following calendar year.

## Indemnity Dental Plan

If you choose coverage under the Indemnity Dental Plan, you may use any dentist you wish. The Plan will reimburse a portion of your dentist's charges according to the Dental Plan Allowances after you meet your annual deductible. You pay any difference between what the Plan pays and what your dentist charges. There is an $1,800 per calendar year maximum benefit per person.

Dental services (except emergency care) rendered outside of the United States are not covered under the Plan, unless you are living abroad permanently. Services performed in Mexico may be covered, if x-rays are supplied with each claim.

## Prepaid Dental Plans

The Prepaid Dental Plans provide many diagnostic, preventive and restorative services at little or no charge to you. However, if you enroll in a Prepaid Dental Plan, you must obtain all of your dental services from that plan in order to receive benefits. There is no calendar-year maximum benefit. A current list of Prepaid Dental Plan offices is available at scufcwfunds.com or from the Fund Office.

If you go to a dentist who is not affiliated with the Prepaid Dental Plan in which you have enrolled, you are responsible for 100% of the cost of such dental services — including charges for emergency services outside of your Prepaid Dental Plan's Service Area.

For a comparison of the Indemnity Dental Plan benefits to those of the Prepaid Dental Plan, please refer to your *Summary of Health Care Plans for Retirees* chart and the *Dental Program for Active Participants in All Plans and All Retirees* booklet.

# Death Benefits

If you are an Eligible Retiree at the time of your death, a benefit of $1,000 to $5,000 (depending on your retirement date) will be paid to your beneficiary. No benefit is payable upon the death of a spouse, domestic partner or child. An Eligible Retiree is one who qualifies for and is enrolled in the Retiree Medical Plan, including an Eligible Retiree enrolled as a dependent under another Eligible Retiree's coverage, and who has made timely payment of all premiums required for coverage. A Death Benefit may also be payable if you qualify for Retiree health and welfare benefits at retirement, but die before becoming eligible for the benefit at age 55. A claim for death benefits must be postmarked or received at the Fund Office within one year of death.

## Naming a Beneficiary

You may name anyone you wish as beneficiary and may change your beneficiary at any time without the consent of the beneficiary. Your initial beneficiary designation and any beneficiary changes you make afterwards take effect on the date the Fund Office receives your beneficiary form, provided it is received by the Fund Office before your death. You may download a beneficiary form from the Fund's website at scufcwfunds.com or get one from your Union Local or the Fund Office.

If no beneficiary is named or surviving upon your death, the Death Benefit will be paid in the order listed below:

1) Your legal spouse, if none then

2) Your children in equal shares, if none then

3) Your parents in equal shares, including adoptive parents, if none then

4) Your siblings in equal shares, if none then

5) If there is no eligible beneficiary then, in lieu of the death benefit, the Fund will pay the person who presents evidence of payment of the Retiree's burial expenses an amount not to exceed $1,000 for the burial expenses.

## How to File a Claim for Death Benefits

If you were eligible for Retiree Medical Plan benefits at the time of your death, and your beneficiary designation was received by the Fund Office before your death, payment will be made in accordance with your designation(s) upon receipt of a certified copy of the death certificate—a claim form is not required. However, a claim for death benefits must be made within one year of your death.

# COBRA Continuation Coverage

The Plan offers COBRA benefits to a retiree's covered spouse or covered child who has a Qualifying Event. Qualifying Events for COBRA for the retiree's spouse include loss of coverage as a result of (a) the retiree's death; or (b) divorce or legal separation from the retiree.

Qualifying Events for COBRA for the retiree's dependent children include loss of coverage as a result of (a) the retiree's death; (b) the retiree's divorce; or (c) the dependent child ceasing to meet the definition of a "dependent" as defined by the Plan.

A child or spouse must notify the Fund Office of the Qualifying Event within 60 days of the date of the event.

**Note:** Your domestic partner and his/her children are not entitled to COBRA coverage on their own and will not be offered the option of electing COBRA coverage. Also, COBRA coverage is not available to any eligible dependent who is not enrolled in the Retiree Medical Plan at the time a Qualifying Event occurs.

Each qualified beneficiary who elects COBRA coverage has the same rights under the Plan as other Participants, including Open Enrollment and Special Enrollment Rights.

Each qualified beneficiary electing COBRA coverage may choose from the following two COBRA coverage options:

- Core Benefits Only: Medical, EMAP, prescription drug and vision coverage; or
- Core-Plus Benefits: Medical, EMAP, prescription drug, vision, and dental coverage.

Once you have made your election for either Core Benefits Only or Core-Plus Benefits, you may not change it.

Benefits provided under COBRA are identical to the benefits provided by the Fund to retirees who are not receiving COBRA coverage.

You can buy only the plan of benefits that you had prior to the Qualifying Event that made you eligible for COBRA coverage, with certain exceptions. For example, if you are enrolled in an HMO, you may not enroll in the Indemnity PPO Medical Plan when you apply for COBRA unless you are moving outside the HMO's Service Area. You may, however, change medical plans during the Fund's annual Open Enrollment period.

The Fund will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Office has been notified that a Qualifying Event has occurred. Contact the Fund Office if you need more information about COBRA.

Once the Fund Office receives notice that a Qualifying Event has occurred, COBRA coverage will be offered to each qualified beneficiary (i.e., your spouse or dependents). Each qualified beneficiary will have an independent right to elect COBRA coverage.

# Benefit Plan Contacts

If you have questions or need more information about the benefits described in this booklet, contact the Fund Office, your Union Local, or the applicable health care plan listed below and on the next page.

| Organization | Phone Number | Address | Website |
|---|---|---|---|
| **Southern California United Food & Commercial Workers Unions and Food Employers Joint Benefit Funds Administration, LLC** | 714-220-2297,<br>562-408-2715, or<br>877-284-2320<br>(see extensions below) | 6425 Katella Avenue<br>Cypress, CA 90630-5238<br>PO Box 6010<br>Cypress, CA 90630-0010 | scufcwfunds.com |
| COBRA | Extension 441 | | |
| Death Benefits | Extension 447 | | |
| Dental | Extension 428 | | |
| Eligibility | Extension 422 | | |
| Enrollment | Extension 420 | | |
| Medical | Extension 424 | | |
| Retiree Enrollment | Extension 445 | | |
| Pension | Extension 434 | | |
| Prescription | Extension 432 | | |
| **Participating Union Locals** | | | |
| **UFCW Local 8 — Bakersfield** | 661-391-5773 or<br>661-391-5770 | 900 Airport Drive<br>Bakersfield, CA 93308 | **ufcw8.org** |
| **UFCW Local 135** | | | **ufcw135.com** |
| San Diego | 619-298-7772 or<br>800-545-0135 | 2001 Camino Del Rio South<br>San Diego, CA 92108 | |
| San Marcos | 619-298-7772 or<br>800-545-0135 | 323-A South Rancho Santa Fe Road<br>San Marcos, CA 92078 | |
| **UFCW Local 324 – Buena Park** | 714-995-4601 or<br>800-244-8329 | 8530 Stanton Avenue<br>Buena Park, CA 90620 | **ufcw324.org** |
| **UFCW Local 770** | | | **ufcw770.org** |
| Los Angeles (Main Office) | 213-487-7070 or<br>800-832-9770 | 630 Shatto Place<br>Los Angeles, CA 90005 | |
| Arroyo Grande | 805-481-5666 | 127 Bridge Street<br>Arroyo Grande, CA 93420 | |
| Camarillo | 805-383-3300 | 816 Camarillo Springs Road, Suite H<br>Camarillo, CA 93012 | |
| Harbor City | 310-784-5340 | 25949 Belle Porte Avenue<br>Harbor City, CA 90710 | |
| Newhall | 661-259-9900 | 23030 Lyons Avenue, #102<br>Newhall, CA 91321-2720 | |
| **Participating Union Locals** | | | |

| Organization | Phone Number | Address | Website |
|---|---|---|---|
| Santa Barbara | 805-681-0770 | 4213 State Street, Suite 201<br>Santa Barbara, CA 93110 | |
| **UFCW Local 1167 — Bloomington** | 909-877-1110 | 855 West San Bernardino Avenue<br>Bloomington, CA 92316 | **ufcw1167.org** |
| **UFCW Local 1428 — Claremont** | 909-626-6800 | 705 West Arrow Highway<br>Claremont, CA 91711 | **ufcw1428.org** |
| **UFCW Local 1442 — Inglewood** | 310-322-8329 | 9075 S. La Cienega Blvd.,<br>Inglewood, CA 90301 | **ufcw1442.org** |

| Health Care Plans | Phone Number | Website |
|---|---|---|
| **Indemnity PPO Medical Plan:**<br>UFCW Unions and Food Employers Benefit Fund | 714-220-2297,<br>562-408-2715, or<br>877-284-2320 | **scufcwfunds.com** |
| **Anthem Blue Cross PPO Networks** | | **anthem.com/ca/** |
| Hospital review/preauthorization | 800-274-7767 | |
| Find a PPO provider – California | 855-686-5613 | |
| Find a PPO provider – Outside California | 800-810-2583 | |
| **Kaiser Permanente HMO** (non-Medicare) | 800-464-4000 | **kp.org** |
| **Kaiser Senior Advantage HMO** | 800-443-0815 | **kp.org/medicare** |
| **UHC Flex HMO** (non-Medicare) | 800-624-8822 | **myuhc.com** |
| **UHC Medicare Advantage HMO** | 800-457-8506 | **uhcretiree.com** |
| **OptumRx – Prescription Drugs** | 888-715-7573 | **optumrx.com** |
| **HMC Employee Member Assistance Program (EMAP)** | 800-461-9179 | **hmchealthworks.com** |
| **Podiatry Plan of California (PPOC)** | 800-367-7762 | **podiatryplan.com** |

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