Benefits+
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# Medical Benefit Highlights

## PLAN A & PLAN B SILVER AND GOLD

United Food & Commercial Workers Unions
and Food Employers Benefit Fund

# Table of Contents

# About this Booklet

This booklet provides general information about benefits provided through the United Food & Commercial Workers Unions and Food Employers Benefit Fund. Because medical coverage is the most valuable benefit in your health care benefits package, this booklet focuses primarily on the Indemnity PPO Medical Plan.

This information is meant to help you make enrollment and health care decisions that best meet the needs of you and your family. This booklet also contains information about eligibility for benefits and payroll deductions.

Please refer to your current *Silver/Gold Benefits* Chart, your *Summary of Benefits and Coverage (SBC)*, and other materials provided by the Fund to learn more about:

- Hospital, surgical, and medical benefits through the Indemnity PPO Medical Plan
- Prescription Drug Program and the Market Priced Drug (MPD) program through any UFCW Unions and Food Employers Participating Network Pharmacy or Mail Service Pharmacy
- Employee Member Assistance Program (EMAP) benefits, provided through HMC HealthWorks (HMC), covering mental/behavioral health care and treatment of substance abuse
- Dental benefits through the Indemnity Dental Plan or a Prepaid Dental Plan
- Orthodontic benefits
- Benefits for vision exams and materials
- Podiatry services through the Podiatry Plan of California (PPOC)
- Death benefits

**If you have questions or need more information**, go to **scufcwfunds.com**, call the Fund Office at 714-220-2297, 562-408-2715, or 877-284-2320 (phone extensions are listed above); or contact your Union Local. Fund Office representatives are available Monday – Friday, 8:00 a.m. to 5:00 p.m., Pacific Time.

## Benefit Fund Phone Extensions

| Benefit Fund Phone Extensions | | | |
|---|---|---|---|
| Eligibility | 422 | Dental | 428 |
| Enrollment | 420 | Orthodontic | 430 |
| Medical | 424 | COBRA | 441 |
| Prescription Drug | 432 | Death Benefits | 447 |

**Phone numbers and websites for the Fund's health care plans and the Union Locals are listed on page 24.**

This booklet is only a brief summary of Plan benefits. Not all provisions, limitations and exclusions have been included. If there is any difference between the information in this booklet and the official Benefit Plan documents, which include Collective Bargaining Agreements, the official Benefit Plan documents govern.

# The Indemnity PPO Medical Plan

## Overview

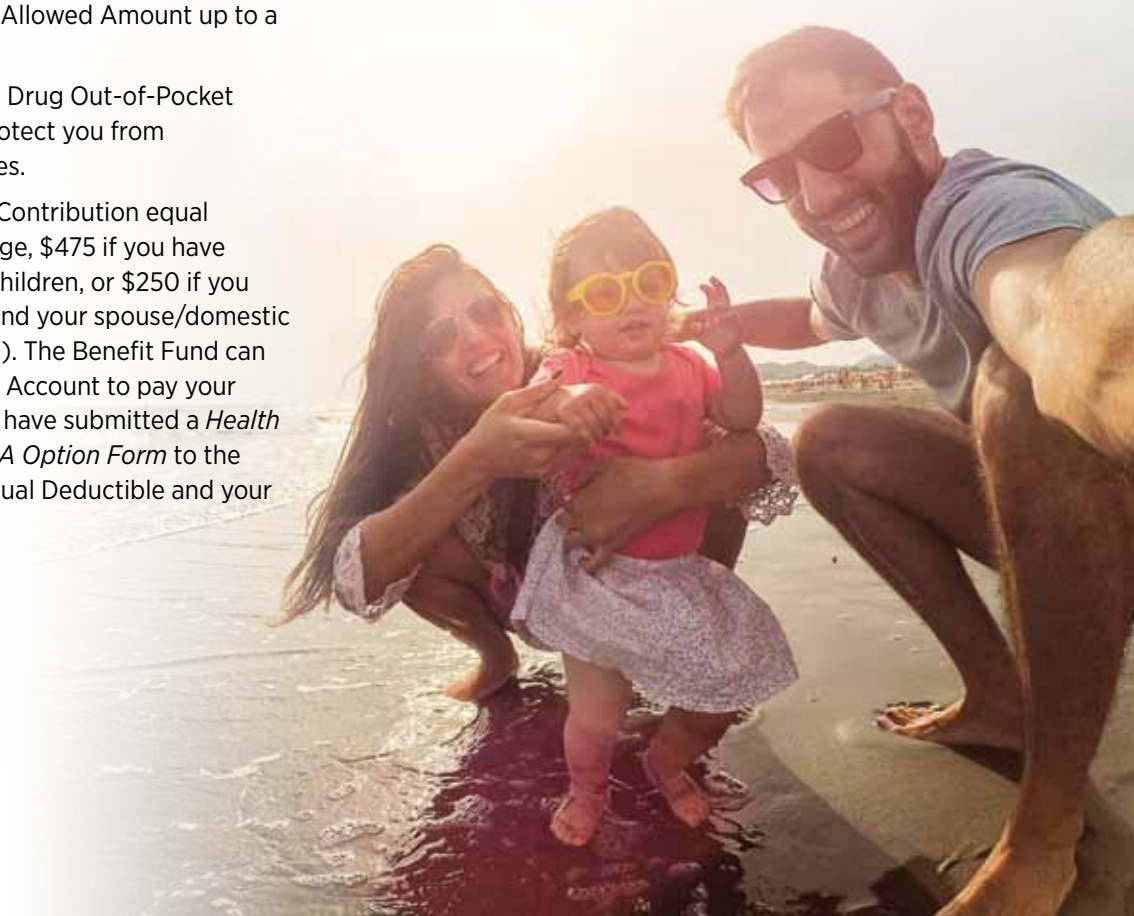
The Indemnity PPO Medical Plan is a preferred provider organization (PPO) plan that combines a Health Reimbursement Account (HRA) with comprehensive medical coverage. In addition to paying benefits when you and your covered family members need medical care, the Plan is designed to help prevent illness and promote wellness.

The Indemnity PPO Medical Plan gives you:

- 100% coverage for preventive care services specified in the Plan's Preventive Care Guidelines when you use PPO providers.
- The freedom to choose the health care providers you want. If you use a PPO doctor, hospital, or other health care provider, you will have the lowest possible out-of-pocket expense. The Plan does not require you to select or have your care coordinated through a primary care physician (PCP). You do not need a referral to see a specialist.
- Comprehensive medical coverage that pays 75% of PPO negotiated charges or 50% of the Plan's non-PPO Allowed Amount after you meet your Annual Deductible. Out-of-network (non-PPO) outpatient surgical center services are payable, after you meet your Annual Deductible, at 50% of the Plan's Allowed Amount up to a maximum of $1,000.
- Annual Medical and Prescription Drug Out-of-Pocket Maximum expense limits that protect you from catastrophic health care expenses.
- An automatic annual Base HRA Contribution equal to $125 if you have single coverage, $475 if you have coverage for yourself and your children, or $250 if you have family coverage (yourself and your spouse/domestic partner, with or without children). The Benefit Fund can use your Health Reimbursement Account to pay your prescription drug copays (if you have submitted a *Health Reimbursement Account Rx-HRA Option Form* to the Fund Office) as well as your Annual Deductible and your Coinsurance.
- An added Earned HRA Contribution when you and/or your covered spouse or domestic partner complete certain "Healthy Activities" from June 1 of one calendar year through May 31 of the following year. Activities include completion of a Health Risk Questionnaire (HRQ), annual flu shots, annual physical exams, health screenings, smoking cessation programs, weight loss programs, regular exercise at a gym, etc.

  Each activity is worth a $125 Earned HRA Contribution, up to a calendar-year maximum of $425 if you have employee-only coverage, $625 if you have coverage for yourself and your children, or $850 if you cover yourself and your spouse/domestic partner (with or without children).

With the Indemnity PPO Medical Plan, you get a lot of flexibility in choosing the care and benefits you receive. But you also have a degree of responsibility. To make it work to your best advantage, you need to make smart health care buying decisions just as you would for any other important purchase.



# Important Medical Plan Terms

**Affordable Care Act (ACA):** A federal statute that reformed U.S. health care insurance. Its formal name is the Patient Protection and Affordable Care Act (PPACA).

**Allowed Amount:** Maximum amount on which payment is based for covered health care services which, in certain instances, 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. The Fund will automatically use your available Health Reimbursement Account balance to help satisfy your Annual Deductible.

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

**HRA:** This is the Fund-provided Health Reimbursement Account. Contributions made to your account each year are used to help pay your share of covered medical and prescription drug expenses. HRA contributions cannot be used to pay dental/orthodontic or vision care expenses.

- **Base HRA Contribution:** The amount the Fund automatically credits to your HRA on January 1 of each year that you are enrolled in the Indemnity PPO Medical Plan.
- **Earned HRA Contribution:** The amounts added to your HRA when you complete certain Healthy Activities (see "My Health/My Choices Incentive Program" page 8).

**Medical Out-of-Pocket Maximum:** This is the maximum amount you have to pay for your in-network covered medical charges. The Medical Out-of-Pocket Maximum includes your medical Coinsurance and Annual Deductible. 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.

- When you use PPO network providers, your Coinsurance and copays will count towards your Medical Out-of-Pocket Maximum.
- Charges for non-PPO provider services only count towards your Medical Out-of-Pocket Maximum if you receive Out-of-Area Benefits.
- Charges incurred at non-network providers (non-PPO providers), charges in excess of Allowed Amount, expenses you incur for services that are not covered, charges in excess of benefit maximums and employee contributions do not count towards your Medical Out-of-Pocket Maximum and are not paid at 100% in the event you reach the Medical Out-of-Pocket Maximum.

## Newborns' and Mothers' Health Protection Act

Group health plans and health insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth, for the mother or newborn child, to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and health insurers may not, under federal law, require that a provider obtain authorization from the plan or the health insurer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Out-of-Area Benefits:** Benefits that apply to Participants who do not have access to PPO providers.

**Prescription Drug Out-of-Pocket Maximum:** There is a separate Prescription Drug Out-of-Pocket Maximum that limits your share of costs for covered prescription drugs. Please see page 21 for more information.

## Women's Health and Cancer Rights

In accordance with federal law, the Indemnity PPO Medical Plan covers 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.

# Important Medical Plan Rules

**All non-emergency services received from non-PPO providers are subject to a higher Annual Deductible and a 50% Coinsurance rate.** Also, the Plan requires all non-emergency hospital and inpatient facility admissions, both PPO and non-PPO, to be pre-certified. There is a 20% reduction in benefits for failure to obtain pre-certification if the covered patient is out-of-area or admitted to a non-PPO facility.

**Pre-certification for hospital and other inpatient facility admissions** is automatically performed if services are received through the Anthem Blue Cross PPO network for medical care, or HMC HealthWorks® (HMC) for mental/behavioral health and substance abuse care. Pre-certification is NOT automatic outside the PPO and HMC networks, so be sure to let your provider know that you need to get pre-certification before being admitted to a hospital or other inpatient facility.

**The Plan limits benefits for certain medical services and supplies.** Refer to your current *Silver/Gold Benefits* Chart for details.

**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 following chart provides an example to compare 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 Medical Out-of-Pocket Maximum.

### Outpatient Surgical Center Benefit Example

| 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 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. Your available Health Reimbursement Account balance may be used for Covered Expenses.

**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 12 for more about EMAP benefits.)

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 24 of this booklet and on the back of your medical ID card.

# Health Reimbursement Account (HRA)

With full coverage for many preventive care services and your Health Reimbursement Account, the Plan can pay benefits even before you meet your Annual Deductible.

The way it works is simple:

- When you go to the doctor or hospital, the Benefit Fund uses the money in your Health Reimbursement Account to pay your portion (Annual Deductible and Coinsurance) of your claims. The Fund will even reimburse you for your prescription drug copays from your available Health Reimbursement Account balance—if you have submitted a *Health Reimbursement Account Rx-HRA Option Form* to the Fund Office.
- When your Health Reimbursement Account is used up, you are responsible for paying the rest of the Annual Deductible, Coinsurance, and prescription drug copays out of your own pocket.
- If you don't use all of your Health Reimbursement Account in one year, the unused balance rolls over to the following year, so you can use it for future covered medical expenses—as long as you remain enrolled in the Plan.
- The Fund will send you quarterly Health Reimbursement Account statements showing Base and Earned HRA (Healthy Activity) Contributions, prescription drug copay reimbursements, payments made for medical claims, and your account balance at the end of each calendar quarter.

### Calendar-Year HRA Funding

| Coverage Category | Single | Employee + Child(ren) | Family* |
|---|---|---|---|
| Automatic Base HRA Contribution | $125 | $475 | $250 |
| Maximum Added Earned HRA Contribution | $425 | $625 | $850 |
| **Total HRA Funding Opportunity (Base + Earned)** | **$550** | **$1,100** | **$1,100** |

** Employee and spouse/domestic partner with or without children.*

If you are eligible for and enrolled in family coverage, both you and your spouse/domestic partner can complete and receive credit for Healthy Activities. Children's activities do not count for HRA funding.

## Health Reimbursement Account Benefit Example

The following example shows how the carryover feature of the Health Reimbursement Account works. It does not necessarily reflect the actual cost of medical services and prescription drugs. For more details about Plan benefits, refer to your current *Silver/Gold Benefits* Chart and *Summary of Benefits and Coverage (SBC)*.

The Participant in this example has enrolled his wife and two dependent children. Everyone in the family always uses PPO providers. The Participant has submitted a *Health Reimbursement Account Rx-HRA Option Form* to the Fund. Also, the Participant and his wife complete Healthy Activities and get the maximum Earned HRA Contribution every year.

In-network benefits for this family include:

- 100% coverage for specific PPO preventive care services with no Annual Deductible[1]
- A $250 automatic Base HRA Contribution and an $850 Earned HRA Contribution ($1,100 total)
- 75% PPO coverage after the $1,000/person or $2,000/family in-network Annual Deductible is met.[2]

1 Preventive care services that are medically necessary but not included in the Plan's Preventive Care Guidelines are also covered, subject to the Plan's Annual Deductibles and Coinsurance percentages.

2 Annual Deductibles are higher for individuals who are eligible for but do not actively participate in the Disease Management Program.

## Health Reimbursement Account Benefit Example—Year One

In year one, the Plan uses $400 of this family's Health Reimbursement Account to pay non-preventive care expenses for the family and $80 to reimburse eight $10 prescription drug copays. At the end of year one, the Plan has paid all of the family's covered health care expenses, and a $620 Health Reimbursement Account balance carries over to year two.

| Covered Services and Prescriptions | Covered Expenses | Medical/Rx Plan Payments | Participant's Responsibility | | HRA Running Balance |
|---|---|---|---|---|---|
| | | | Amounts Paid from HRA | Out-of-Pocket Costs | |
| Annual physicals from PPO doctor for all four family members | $500 | $500 | 0 | 0 | $1,100* |
| Four non-preventive PPO office visits subject to the Annual Deductible | $400 | 0 | $400 | 0 | $700 |
| Eight 30-day preferred formulary generic prescriptions | $480 | $400 | $80 | 0 | $620 |
| **Totals for year one** | **$1,380** | **$900** | **$480** | **0** | **$620 HRA carryover to year two** |

** Health Reimbursement Account beginning balance (year-one Base HRA Contribution plus Earned HRA Contributions).*

## Health Reimbursement Account Benefit Example—Year Two

In year two, the Plan uses the family's Health Reimbursement Account to pay $800 in non-preventive care expenses and six $10 prescription drug copays totaling $60. At the end of year two, the Plan has paid all of the family's covered health care expenses, and an $860 Health Reimbursement Account balance carries over to year three.

| Covered Services and Prescriptions | Covered Expenses | Medical/Rx Plan Payments | Participant's Responsibility | | HRA Balance |
|---|---|---|---|---|---|
| | | | Amounts Paid from HRA | Out-of-Pocket Costs | |
| Annual physicals from PPO doctor for all four family members | $540 | $540 | 0 | 0 | $1,720* |
| Eight non-preventive PPO office visits subject to the Annual Deductible | $800 | 0 | $800 | 0 | $920 |
| Six 30-day preferred formulary generic prescriptions | $360 | $300 | $60 | 0 | $860 |
| **Totals for year two** | **$1,700** | **$840** | **$860** | **0** | **$860 HRA carryover to year three** |

** Health Reimbursement Account beginning balance ($620 carryover from year one + $1,100 year-two Base HRA Contribution plus Earned HRA Contributions).*

## Health Reimbursement Account Benefit Example—Year Three

In year three, this family has $5,000 in non-preventive care expenses. The family's $1,960 Health Reimbursement Account balance is used to pay all but $40 of the $2,000 family Annual Deductible. Then the Plan pays 75% of the remaining $3,000 of charges, or $2,250.

After the Health Reimbursement Account is exhausted, the family pays the $40 remaining Annual Deductible and $750 in Coinsurance, for a total of $790 in out-of-pocket expenses for non-preventive care. The family also pays $60 in prescription drug copays, bringing their total out-of-pocket cost to $850 in year three.

*Health Reimbursement Account Benefit Example—Year Three (continued)*

There is nothing left in their Health Reimbursement Account to carry over. However, the family will have a $1,100 Health Reimbursement Account beginning balance on January 1 of year four (provided that the Participant and his wife are eligible and earn the maximum annual Earned HRA Contribution available for their Healthy Activities).

| Covered Services and Prescriptions | Covered Expenses | Medical/Rx Plan Payments | Participant's Responsibility | | HRA Balance |
|---|---|---|---|---|---|
| | | | Amounts Paid from HRA | Out-of-Pocket Costs | |
| Annual physicals from PPO doctor and related lab tests for four family members | $1,000 | $1,000 | 0 | 0 | $1,960* |
| Non-preventive PPO care (including hospital services) subject to the Annual Deductible for two family members | $5,000 | $2,250 | $1,960 | $790 | $0 |
| Six 30-day preferred formulary generic prescriptions | $360 | $300 | 0 | $60 | $0 |
| **Totals for year three** | **$6,360** | **$3,550** | **$1,960** | **$850** | **$0 HRA carryover to year four** |

** Health Reimbursement Account beginning balance ($860 carryover from year two + $1,100 year-three Health Reimbursement Account Base plus Earned HRA Contributions).*

## Health Reimbursement Account Claims

### Medical Expenses

When you use a PPO provider, your provider will submit claims to the Benefit Fund on your behalf. Payments will be sent directly to providers who submit claims.

Covered Expenses, including your medical Annual Deductible and Coinsurance, will be paid from your Health Reimbursement Account until your account is exhausted. The reimbursed amount counts toward satisfying your Annual Deductible.

If your Health Reimbursement Account is exhausted and you have met your Annual Deductible, the Plan will pay a percentage of your Covered Expenses (75% of PPO charges or 50% of the non-PPO Allowed Amount). The Plan pays 100% of covered expenses after you have met the Medical Out-of-Pocket Maximum.

If your provider does not file a claim on your behalf, you may have to pay that provider and submit a claim to the Fund Office for reimbursement of the covered amount. PPO providers have agreed to submit claims for you—another good reason to use them.

### Prescription Drug Expenses

If the Fund Office has received a *Health Reimbursement Account Rx-HRA Option Form* from you, you will pay the applicable copay for prescription drugs when you receive them. Then the Fund will use your available HRA balance to reimburse you directly for eligible prescription drug copays until your HRA is exhausted. If you don't opt in by filling out the form, your prescription drug copays cannot be reimbursed from your HRA, and the Fund will not accept separate claims to reimburse these costs.

If you want the Fund to use your HRA to reimburse your prescription drug copays, you must submit a *Health Reimbursement Account Rx-HRA Option Form* to the Fund.

***Health Reimbursement Account Rx-HRA Option Forms*** are mailed to un-enrolled Participants during Open Enrollment and to new Participants following initial enrollment. If you have already submitted a form to the Fund, you do not have to submit another one unless you want to opt out of HRA prescription drug reimbursement. Forms are also available at **scufcwfunds.com**, from the Fund Office, and from your Union Local.

# My Health/My Choices Incentive Program

The My Health/My Choices Incentive Program enables you to increase your Health Reimbursement Account balance by doing Healthy Activities related to good health. When you complete a Healthy Activity, your HRA gets an "Earned HRA Contribution". Earned HRA Contributions are in addition to your "Base HRA Contribution", which is the amount provided automatically to your HRA each year.


The more Healthy Activities you do, the more Earned HRA Contributions you get and the less you pay from your own pocket for care. Activities include updating contact information for you and your primary doctor, completion of a Health Risk Questionnaire (HRQ), annual flu shots, annual physical exams, health screenings, smoking cessation programs, weight loss programs, regular exercise at a gym, etc. Each activity is worth $125, up to the maximum total calendar year HRA funding opportunity amounts shown in the chart on page 5.

**Earned HRA Contributions are not automatic.** You and your enrolled spouse/domestic partner (if applicable) must complete a minimum number of activities within one year in order to receive the maximum annual contribution to your Health Reimbursement Account on the following January 1. For more information about this program, refer to the Fund's *My Health/My Choices Incentive Program Planner*. You may download a copy from **scufcwfunds.com** or request a copy from your Union Local or the Fund Office.

## Why Earning HRA Contributions Is Important to You

The automatic Base HRA Contribution to your HRA is much less than what you need to pay your Annual Deductible. You can earn additional money to your HRA to pay your Annual Deductible by doing Healthy Activities.

Bottom line: The bigger your HRA balance is, the more the Plan will pay toward your covered medical and prescription drug expenses, and the less you will have to pay out of your own pocket.

# Health Risk Questionnaire (HRQ)

The HRQ is one of the easiest ways to get Earned HRA Contributions. Every year that you (and your spouse/domestic partner) complete the HRQ, you receive:

- Confidential feedback on health areas where you might be at risk (potential issues with heart disease, high blood pressure, or diabetes, for example)
- An Earned HRA Contribution equal to $125 if you complete the HRQ, or $250 if you have family coverage and both you and your spouse/domestic partner complete the HRQ

The HRQ is **strictly confidential**. The Fund Office, your Employer, and your Union will not have access to any of your health information. For administrative purposes, the Fund Office may exchange your home address, telephone number, date of birth, Family ID number, and Social Security number with the HRQ vendor. HMC, the HRQ vendor, may share some of your answers with the Fund's health care contractors, such as its pharmacy benefit manager. For more information, please see the HMC's Privacy Policy.

# Preventive Care Benefits

When you receive in-network (PPO) preventive care services specified in the Plan's Preventive Care Guidelines, the Plan pays 100% of the negotiated charges with no Annual Deductible and without using your Health Reimbursement Account. What's more, some preventive care services also qualify for Earned HRA Contributions under the My Health/My Choices Incentive Program.

If you have access to PPO providers and choose to receive preventive care outside the PPO network, the Plan will pay 50% of the Plan's non-PPO Allowed Amount after you meet your Annual Deductible. (Refer to your current *Silver/Gold Benefits* Chart for more information.)

It's a good idea to call the Fund Office to find out if the Annual Deductible applies and how much the Plan will pay *before* getting a preventive care exam or test. Also, to receive the most cost-effective benefit possible, always use PPO providers. Refer to the Plan's *Preventive Care Guidelines* brochure for the list of covered services, limitations, ages and frequency. You may download a copy from the Fund's website at **scufcwfunds.com** or contact the Fund Office to request a copy.

The Plan's Preventive Care Guidelines are based on recommendations from leading health organizations including the U.S. Department of Health Centers for Disease Control and Prevention, the American Academy of Family Physicians, and the American Academy of Pediatrics as well as requirements set by the ACA.

The following chart gives a brief overview of some of the preventive care services that the Plan covers at 100% with no Annual Deductible when you use PPO network providers.

### Overview of Some Preventive Care Guidelines

| Covered Service | When Covered |
|---|---|
| Childhood and adult immunizations<br>Well-baby care | Age-appropriate per the Plan's Preventive Care Guidelines |
| Routine physical exam (adult)* | Annually |
| Papanicolaou (PAP) smear and pelvic exam (female)* | Annually |
| Sigmoidoscopy or colonoscopy screening for colorectal cancer* | For average risk persons, every 5 years starting at age 50 |
| Mammogram (female)* | For average risk women, every 1 – 2 years starting at age 40 |
| Prostate specific antigen (male)* | For average risk men, annually (PSA) test starting at age 18 |

** These preventive services and flu shots for you and your covered spouse/domestic partner qualify for Earned HRA Contributions.*

# Disease Management Program

The Disease Management Program is a valuable Indemnity PPO Medical Plan benefit for Participants and their enrolled spouses/domestic partners who suffer from heart disease and related conditions, asthma, or diabetes. It is designed to help them prevent or minimize the effects of their disease.

If you are identified as moderate to high risk for one of these conditions, you'll receive a letter from the Fund advising you that the Program's administrator, HMC, will call you to advise if you qualify to participate in the Program. If you do qualify, once you are enrolled and are actively participating in the program, you will be entitled to lower prescription copays and additional contributions to your HRA (lowering your out-of-pocket expenses).

If you choose not to enroll in the Disease Management Program, your Annual Deductible will be higher (increasing your out-of-pocket expenses).

# 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.

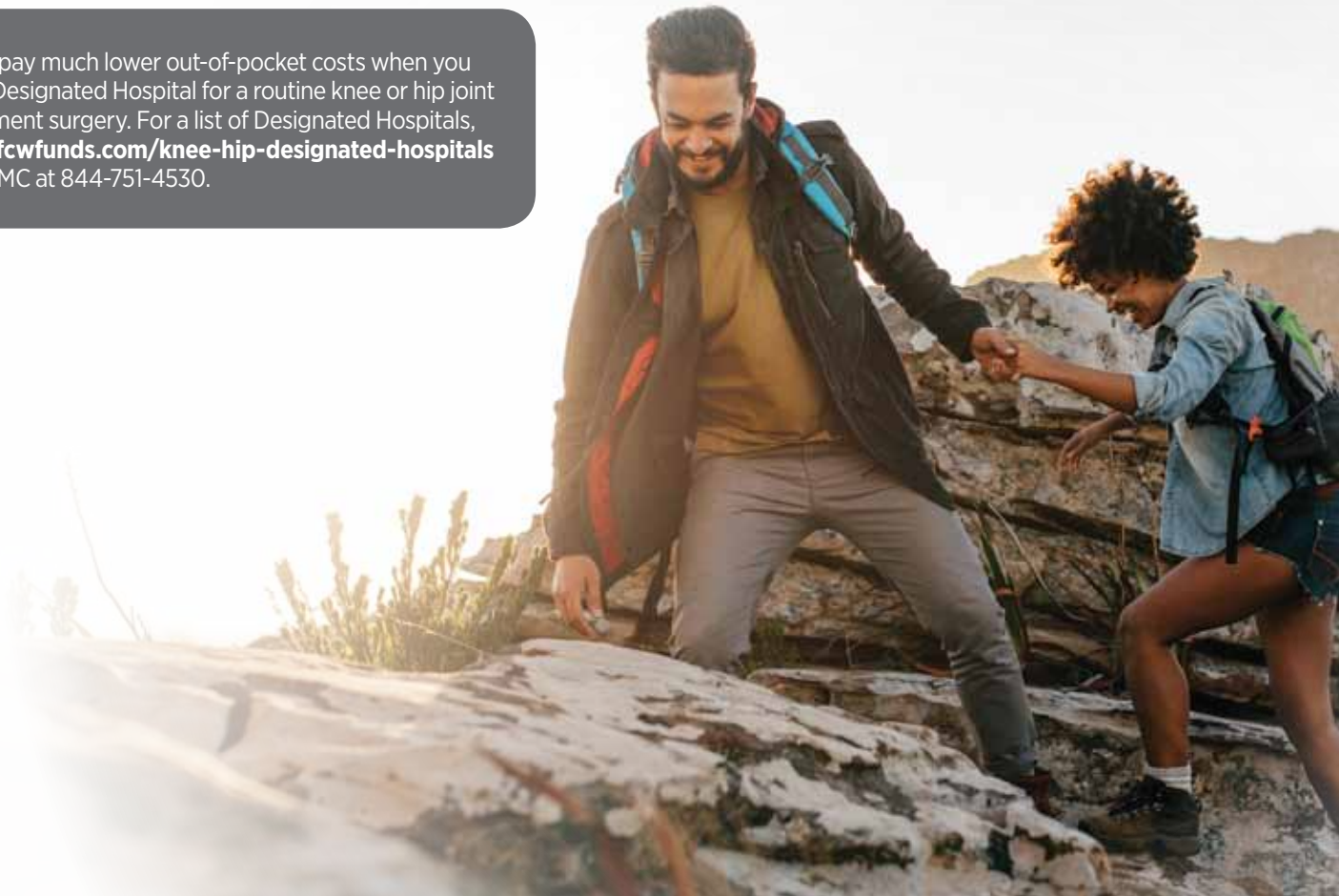
## Designated Hospitals

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.

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. For a list of Designated Hospitals, visit **scufcwfunds.com/knee-hip-designated-hospitals** or call HMC at 844-751-4530.

## How the Knee/Hip Replacement Hospital Benefit Works

- **If you have your knee or hip replacement surgery at a Designated Hospital**, you will have no out-of-pocket costs beyond your Annual Deductible and your Coinsurance (25% of covered charges). You need to meet your Annual Deductible and pay your share of Coinsurance (both payable from your Health Reimbursement Account balance, if any). After you reach the Plan's annual Medical Out-of-Pocket Maximum, the Plan pays 100% of the remaining charges.
- **If you have your knee or hip replacement surgery at a non-Designated Hospital**, your out-of-pocket costs may 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. You cannot use your Health Reimbursement Account balance to pay charges that exceed the Allowed Amount. In addition, the Plan's **Medical Out-of-Pocket Maximum** will not limit your share of the costs.



## Knee/Hip Replacement Hospital Benefit Example

Your share of costs will be much lower when you use a Designated Hospital. Know before you go. The example below is based on the Medical Out-of-Pocket Maximum effective on January 1, 2018.

| | 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) | | | |
| | **$3,500**<br>You pay your $1,000 Annual Deductible plus 25% Coinsurance until you reach your Medical Out-of-Pocket Maximum of $3,500 | **$8,250**<br>You pay your $1,000 Annual Deductible plus 25% Coinsurance on remaining Allowed Amount ($29,000 x 25% = $7,250) | **$15,600**<br>You pay your $1,200 Annual Deductible plus 50% Coinsurance on remaining Allowed Amount ($28,800 x 50% = $14,400) |
| Part Two: The Plan pays the remaining share toward the Allowed Amount (or the hospital charge if lower) | | | |
| | $18,500<br>($22,000 minus $3,500) | $21,750<br>($29,000 x 75%) | $14,400<br>($28,800 x 50%) |
| Part Three: You pay all charges over the Allowed Amount of $30,000 | | | |
| | $0 | $5,000 | $12,000 |
| **Your out-of-pocket cost:** | **$3,500** | **$13,250** | **$27,600** |

## Not All Anthem Blue Cross PPO Hospitals are Designated Hospitals!

Because your costs may be so much higher at a non-Designated Hospital, it's 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.

## If You Don't 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. The $30,000 Allowed Amount will not apply.

# Employee Member Assistance Program

The Employee Member Assistance Program (EMAP) is a benefit that offers support services and referrals to mental/behavioral health specialists for Participants and family members enrolled in the Benefit Fund's Indemnity PPO Medical Plan. The EMAP covers inpatient and outpatient mental/behavioral health and substance abuse care, and is designed to help you and your covered family members resolve personal problems in the early stages.

HMC HealthWorks® (HMC) administers the EMAP. HMC's provider network includes psychiatrists, psychologists, therapists, marriage/family/child counselors, hospitals, acute care facilities, and rehabilitation centers.

### The EMAP Offers Help with Personal Problems Such as These

- Stress
- Aging
- Anxiety
- Family
- Work
- Finances
- Parenting
- Grief/loss
- Relationships
- Marriage
- Alcohol/drug
- Depression

## How the EMAP Works

Whenever you or your covered dependent needs help with behavioral/mental health or substance abuse problems, you call HMC HealthWorks at 800-461-9179, night or day. An HMC Care Manager will refer you to a network provider near your work or home and help you schedule appointments. To help make sure you receive proper care, your Care Manager will also follow your treatment every step of the way.

HMC's Care Managers are master's degree level clinicians dedicated to helping you and your covered family members receive the most appropriate care when you need it.

**All discussions between you, your Care Manager, and your provider are confidential.** Information about your EMAP services cannot be released without your written consent, except by court order, imminent threat of harm to self or others, or in situations of physical or mental abuse.

## Who Pays for EMAP Services

The Benefit Fund pays for EMAP services the same way as it does for any other medically necessary health care service covered under the Indemnity PPO Medical Plan. After you meet your Annual Deductible, the Benefit Fund pays 75% of Covered Charges from HMC network providers. If you use a provider that is not in the HMC network, the Benefit Fund will pay only 50% of the Allowed Amount, which may be much lower than what an out-of network provider might charge. In other words, you will pay a lot more for your care if you use an out-of-network provider

## Pre-certification Requirements

Pre-certification is required for non-emergency in-patient hospital and rehabilitation facility services. When HMC coordinates the admission, pre-certification is automatic. However, if you are admitted to a hospital or other facility without pre-certification by HMC, your benefits will be reduced by 20%.

To make sure you receive maximum EMAP benefits, always call HMC before receiving outpatient or inpatient services for mental/behavioral health or substance abuse care.

## Online Help

You can explore topics that are important to you in a confidential and anonymous manner at any time. Just go to the HMC website at **hmc.personaladvantage.com**.

HMC's website offers a wide variety of self-help tools, articles, and videos focused on helping you and your family deal with personal problems. Everyone in your household can register individually and take advantage of the website.

# Coordination of Benefits (COB)

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

If you have other insurance besides the coverage through this Fund, one of the plans is the primary plan while the others are secondary plans. The primary plan pays benefits first without regard to the amount of coverage provided by the other plans. 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.

If the Fund's Plan is secondary and another plan is primary, then benefits will be determined as follows:

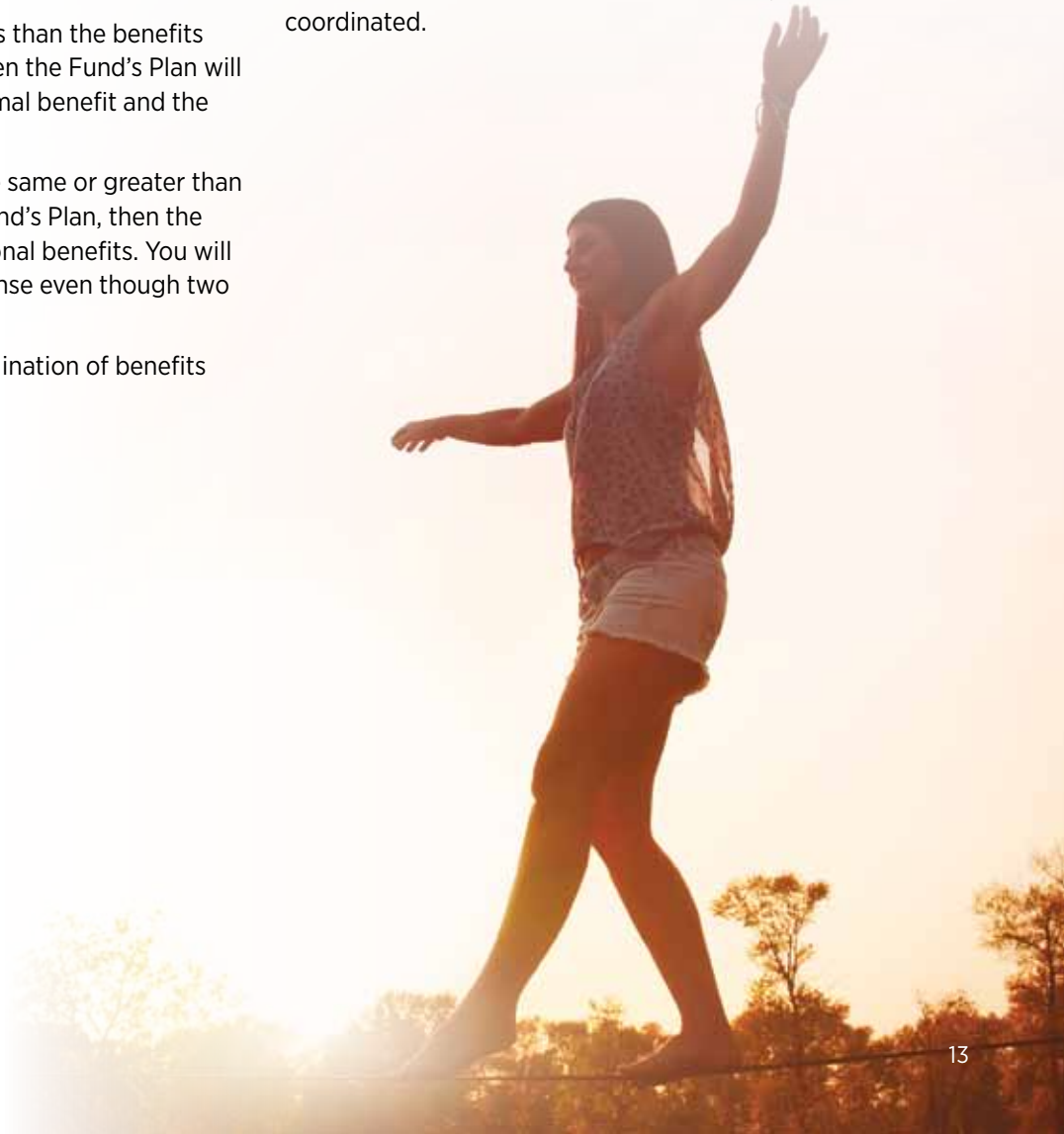
- If the primary plan's payment is less than the benefits provided under the Fund's Plan, then the Fund's Plan will pay the difference between its normal benefit and the amount paid by the primary plan.
- If the primary plan's payment is the same or greater than the benefits provided under the Fund's Plan, then the Fund's Plan will not pay any additional benefits. You will 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.

The following examples assume your Annual Deductible has been satisfied but the **Medical Out-of-Pocket Maximum has not been reached**.

**COB Example 1:** Your primary plan pays 50% and the Fund's Plan usually pays 75% for medical treatment. Should you have medical expenses, your primary plan will pay 50% and this Plan will pay 25%. You will pay the remaining 25%.

**COB Example 2:** If your primary plan pays 75% and the Fund's Plan usually pays 75%, the Fund's Plan will not pay anything since 75% is what the Fund's Plan would have paid if it were primary. You will pay the remaining 25%.

**If both you and your spouse/domestic partner are eligible for benefits through the Fund via Required Hours**, contact the Fund Office for information about how your benefits are coordinated.



# Health Care Enrollment Requirement for Working Spouses and Domestic Partners

The Fund's health care plans coordinate with other employers' health care plans to ensure that those other plans share some of the cost of benefits for working families. The Fund requires that if your spouse/domestic partner is eligible for other health care coverage through his or her own employment, he or she must enroll in the best health care plans (medical, dental, orthodontic, vision, hearing, etc.) for employee-only coverage offered through that employer, even if those plans require payment of a premium by the spouse/domestic partner.

If your spouse/domestic partner's employer offers a choice of plans and he or she is enrolled in the best plans available for employee-only coverage from his or her own employer, the Fund will pay secondary, paying benefits for your spouse/domestic partner according to its COB rules.

If your spouse/domestic partner is not working now but becomes eligible for coverage through employment in the future, he or she must enroll in the best health care plans available for employee-only coverage at the earliest opportunity. Anytime there is a change in your spouse's/domestic partner's health care coverage, you must notify the Fund Office immediately. Failure to do so will result in reduced benefits as described directly below.

## Working Spouse/Domestic Partner Rule

If your working spouse/domestic partner does not enroll in the best health care benefits for employee-only coverage available through his or her employer, the Fund's plans will pay only 40% of the Plan benefit (i.e., what the Fund would otherwise pay) on claims for your spouse/domestic partner. In other words, benefits for your spouse/domestic partner will be **reduced by more than 50%!**

This rule does not affect coverage for dependent children. Only your spouse/domestic partner is required to enroll in the best employee-only health care coverage that is available to him or her.

### Example of Penalty for Not Following Working Spouse/Domestic Partner Enrollment Requirement

| | Plan Benefit after Annual Deductible | Benefit after Annual Deductible for Spouse/Domestic Partner Who Doesn't Enroll in Employer's Best Plan |
|---|---|---|
| Covered In-Network Charges | $1,000 | $1,000 |
| Plan Benefit paid by the Fund | $750 (75% x $1,000) | $300 (40% x $750) |
| **You Pay** | **$250** | **$700** |

Periodic dependent eligibility audits are conducted to make sure that benefits are paid according to the Plan's rules—including the health care enrollment requirement for working spouses and domestic partners. If benefits have been overpaid on behalf of your spouse/domestic partner who is not enrolled in his or her employer's best employee-only plan, you will be required to reimburse the Fund for the full amount of the overpayment.

# Eligibility for Benefits

## Initial Eligibility

To earn your initial eligibility for coverage under the Plan, you must meet the requirements for both length of service and Required Hours (as shown below) for your job classification. Once coverage begins, you must continue to work the Required Hours in each month to earn continuous eligibility.

### Required Hours

You must work the following Required Hours each month to have continuing health care coverage for yourself and your eligible dependents.

| Job Classification | Required Hours |
|---|---|
| Plan A Clerks, Meat Clerks and General Merchandise Clerks: | 92 |
| Plan B Clerks: | 76 |
| Plan A & Plan B Meat Cutters and Uniform Department Employees: | 76 |
| Plan A Clerk's Helpers: | 64 |
| Plan B Utility Clerks: | 64 |

### Your Contributions to the Cost of Coverage

Participants are required to pay a share of the cost of coverage through weekly payroll deductions. If you fall behind in your contributions, the Fund will temporarily increase your deductions to recover the amount you owe. If your Employer is unable to withhold your contributions for an extended period, you may have to make a direct payment to the Fund Office.

### When Eligibility Begins

#### Employees Other than Clerk's Helpers and Utility Clerks

You are eligible to enroll in the Plan to cover yourself only, or yourself and your eligible dependent children, beginning the first day of the calendar month following your sixth month of employment. However, following your initial month of employment, you must have worked at least 20 hours in each of the next three months and the Required Hours in the fifth month.

Your spouse/domestic partner becomes eligible to participate in the Plan on the first day of the calendar month following 60 days after you have worked 1,200 hours, provided you pay the full cost of coverage for your spouse/domestic partner. After you have worked 24 months, the cost of covering your spouse/domestic partner drops to the applicable weekly contribution provided under your collective bargaining agreement, and will be deducted through payroll.

#### Clerk's Helpers and Utility Clerks Who Work the Required Hours Each Month

If you have been employed for at least 18 months, you are eligible to enroll in the Plan to cover yourself only, or yourself and your eligible dependent children, beginning the first day of the calendar month following your 18th month of employment in accordance with your collective bargaining agreement (your spouse/domestic partner is not eligible for coverage). You must work the Required Hours in the 17th month for initial coverage in the 19th month.

You may qualify for coverage sooner as a result of changes required by the Patient Protection and Affordable Care Act (PPACA) as follows: (1) If you average 30 or more hours per week during your first 11 full months of employment, you may be eligible to enroll at additional cost, starting in your 14th month of employment; or (2) If you do not qualify under (1) above, you still may be eligible to enroll before your 19th month, when you reach 1200 hours of service, by paying the full cost of coverage.

## Continuing Eligibility

If you are promoted, you will receive credit for purposes of medical plan eligibility from your original date of hire.

Continuing eligibility is earned based on a "skip-month" rule. You will be eligible for benefits during the second month following the month in which you worked the Required Hours. Your eligibility will also continue if you qualify for an approved leave of absence. Your eligibility will continue to be earned based upon the "skip-month" rule when you return from your leave in a timely manner. Contact the Fund Office for more information about such extensions of coverage.

You cannot extend your eligibility with disability credits if you go on a disability leave of absence. However, you may elect COBRA coverage to continue your eligibility during a period of certified occupational or non-occupational disability.

Remember, you should still submit proof that you are receiving workers compensation or state disability benefits to prevent a break in service.

**Example:** Hours worked in April are reported in May and give you eligibility in June. If you work enough hours in April but not enough hours in May, your eligibility will terminate on June 30 and you will not have July eligibility.

Your eligibility may terminate for reasons other than a lack of Required Hours. Your eligibility will cease at the end of the month in which your employment is terminated or you are laid off.

If your eligibility ceases because your employment was terminated, you were laid off or you failed to earn the Required Hours for eligibility, you may elect COBRA Continuation Coverage. You must pay the required COBRA payments on time.

## How to Reestablish Eligibility

If you have already established initial eligibility, are laid off or terminated and return to work in fewer than 120 consecutive days, you will reestablish eligibility on a skip-month basis if you work the Required Hours (e.g., an employee who works the Required Hours in July will earn eligibility for benefits for the month of September).

If your employment is terminated and you are rehired by your same Employer, or another Employer, before the end of the month in which your coverage ends, your coverage can continue without interruption (e.g., if you terminate with Employer A on July 15th and are hired by Employer B on July 18th, you will remain covered in August. And, provided you work sufficient hours in July between both Employer A and Employer B, you will also be covered in September).

If you are laid off or terminated and you return to work after 120 consecutive days, you will have to reestablish initial eligibility. If you are laid off for more than 120 days but are recalled by your same employer within 12 months, your eligibility will be reestablished on a skip-month basis.

**Example:** Jack enrolls for benefits during Open Enrollment, and his coverage takes effect on January 1. He does not work the Required Hours in February to maintain those benefits in April. However, he works the Required Hours in March and will again have benefit coverage in May. He can make a COBRA payment to cover April if he wishes.

The following year, Jack's employment is terminated in June but he is then rehired in August. Since he is rehired in less than 120 days, he can reestablish his eligibility on a skip-month basis as soon as he works the Required Hours. If he works enough hours in August (the month of his rehire), he will be eligible for benefits in October. If Jack is rehired more than 120 days after his termination, he will be required to meet the initial eligibility rules outlined previously.

However, if Jack is laid off and is recalled by his employer to return to work within the 12-month recall window, he can reestablish eligibility on a skip-month basis as soon as he works the Required Hours. In this same recall scenario, if Jack was laid off before he established initial eligibility, the number of months worked prior to his layoff will count towards his initial eligibility waiting period.

# Benefit Upgrades

Plan Participants other than Clerk's Helpers and Utility Clerks can earn upgrades to their benefits after reaching certain employment service milestones. They can "step up" from their initial Silver benefits package to Gold after 3½ years of employment and "graduate" to the Platinum benefits level after 5½ or 6½ years of employment, depending on their date of hire as shown below.

## Step-up Benefits

Eligible Participants step up from the Silver level to the Gold level of benefits the month after completing 3½ years of employment. Enhancements include lower prescription drug copays and higher annual maximum dental and orthodontic benefits as shown on your *Silver/Gold Benefits* Chart.

## Graduation to Platinum Benefits

Eligible Participants graduate from the Gold level to the Platinum level of benefits upon completing the following service requirements:

- Plan A Participants hired after March 1, 2004 and before July 22, 2007, and Plan B Participants hired on or after October 4, 2004 and before October 12, 2007, graduate to Platinum the month after completing 5½ years of employment.
- Plan A Participants hired on or after July 22, 2007, and Plan B Participants hired on or after October 12, 2007, graduate to Platinum the month after completing 6½ years of employment.

In addition to step-up benefit upgrades, Platinum medical benefit enhancements include larger contributions to your Health Reimbursement Account and lower annual PPO Medical Out-of-Pocket Maximum limits. You will receive more information about Platinum benefits when you approach graduation.

Your weekly payroll deduction will not change because of a step up to Gold benefits or graduation to Platinum benefits.

# Eligible Dependents

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

- Your legally married spouse (does not apply to Clerk's Helpers and Utility Clerks)
- Your domestic partner* with whom you have a Certificate of Registration of Domestic Partnership filed with the California Secretary of State (does not apply to Clerk's Helpers and Utility Clerks)
- Your child(ren) under age 26, if they are your:
  - Natural child
  - Legally adopted child
  - Step-child
- Your domestic partner's child(ren) who meet the following criteria:
  - They are unmarried, and
  - They are totally dependent on you for support and maintenance, and
  - They are (a) under age 19, or (b) under age 24 and a full-time student at an accredited educational institution.
- A foster child, including:
  - A foster child placed by a government agency or court order, under age 26
  - A foster child whose status is established by a Natural Parents' Certification, and who meets the requirements outlined in the Fund's *Application for Coverage of a Foster Child as an Eligible Dependent* form.
- An "over-age" disabled child who is unmarried, unemployable, and totally dependent on you because of a permanent mental or physical disability, including:
  - Your natural child, legally adopted child, or step-child. Coverage may be provided to the child over age 25 if his or her disability began prior to age 26.

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

- Your domestic partner's child. Coverage may be provided to the child over age 18 if his or her disability began prior to: (1) age 19, or (b) between the ages of 19 and 24 while covered as a dependent, and a full-time student at an accredited educational institution.
  - A foster child placed by a government agency or court order. Coverage may be provided to the child over age 25 if his or her disability began prior to age 26 or as required by applicable law.
  - A foster child that is ***not*** placed by a government agency or court order who is dependent on you for support. Coverage may be provided to the foster child over age 18 if his or her disability began prior to: (1) age 19, or (2) between the ages of 19 and 24 while covered as a dependent, and a full-time student at an accredited educational institution.

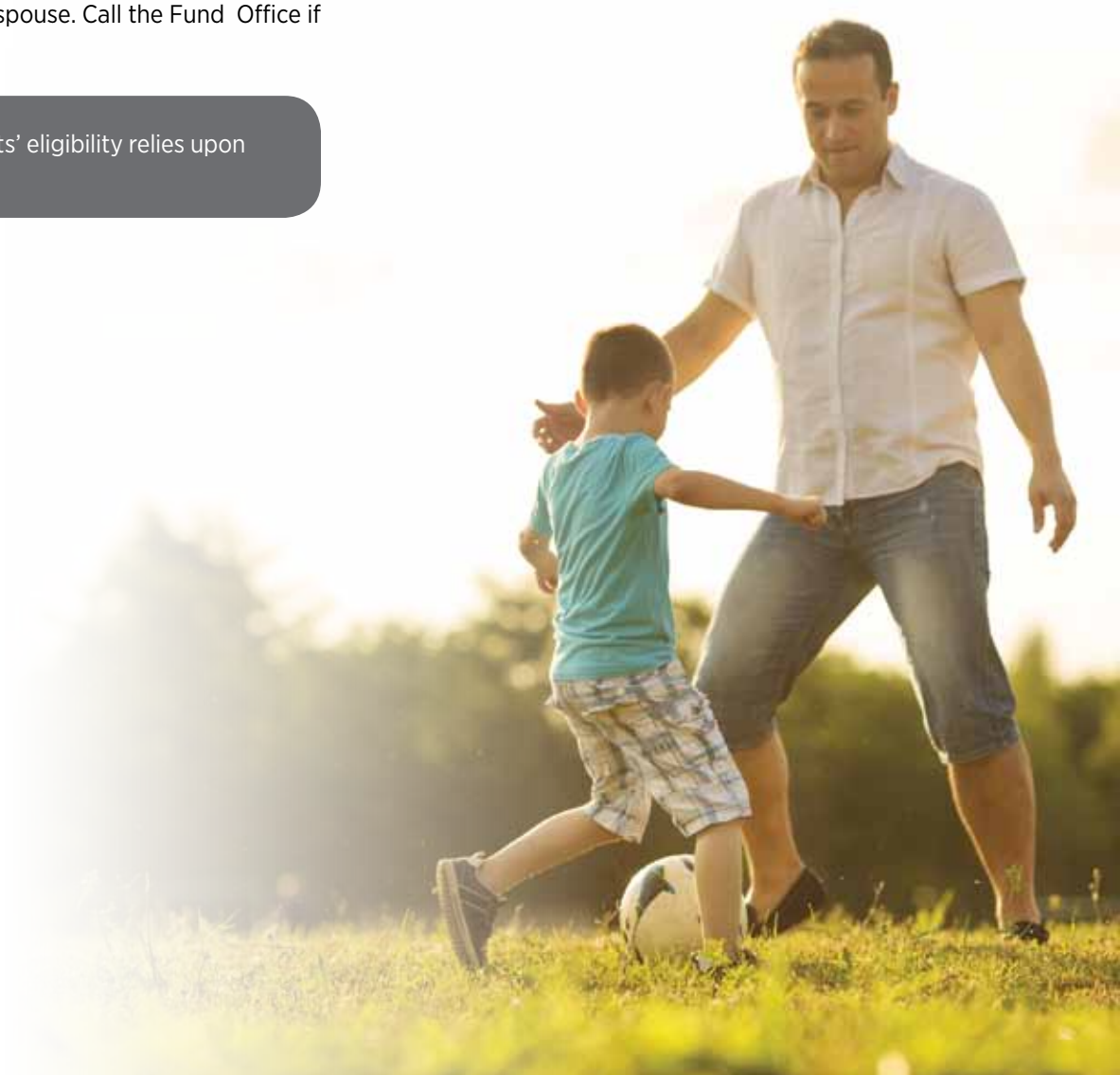
Note that you might be responsible for paying taxes on the imputed value of the coverage being provided to your domestic partner or same-sex spouse. Call the Fund Office if you need more information.

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

## Dependent Verification 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. 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, you will be required to reimburse the Fund for the full amount paid on their behalf.**



# Payroll Deductions

Participation in the Fund's health care plans requires you to authorize your Employer to deduct from your weekly wages the amount needed to pay your share of the cost of coverage. The deduction is taken "pre-tax" (before taxes are withheld from your pay) or "post-tax" (after taxes are withheld), as determined by your Employer. The following information is provided to help you understand how the payroll deduction process works.

## What happens to the money that is deducted from my wages?

Your Employer forwards the deducted amounts to the Benefit Fund.

## Is the same amount deducted from my paycheck every week?

No. Amounts may be adjusted for periods when deductions are not taken from your wages (for example, when you are not scheduled to work because of a vacation or other reason).

## Do the amounts deducted from my wages in the current month pay for coverage in the same month?

Yes. Deductions taken in the current month pay for coverage in that month. However, additional amounts may be deducted to make up for missed contributions (for example, when you are not scheduled to work because of a vacation or other reason).

## What happens if too much money is deducted from my paycheck?

If your account has a balance and you still have active coverage, your deductions will be reduced until that balance has been used. For example, if your coverage level changes retroactively from "Family" to "Single" your deductions will be reduced or stopped until the balance is used. If you terminate your coverage and still have a balance, your Employer can refund directly to you any money deducted from your wages that should not have been deducted.

## Am I allowed to drop my coverage and stop my payroll deductions whenever I want?

No. You are not allowed to drop your coverage except during annual Open Enrollment unless a status change* occurs or if there is a change in the weekly deduction rate. You must contact the Fund Office on or before December 31 of that same year to cancel your payroll deductions and drop your coverage for the following year.

## Will I lose my Gold step-up benefit status if I drop my coverage?

No. Status is lost after 120 or more days with no hours worked following a termination of employment. See "How to Reestablish Eligibility" on page 16.

## If I drop my coverage, may I enroll again in the future?

Yes. You may enroll during the next annual Open Enrollment or if you have a status change*. Your payroll deductions will begin during the first complete payroll period in the month after the date your Employer is advised by the Fund Office.

## What if I am no longer eligible for coverage?

If you cease to be eligible to participate in the Benefit Fund or if your job classification is changed to one that is not covered under the Collective Bargaining Agreement, contact the Fund Office or your Union Local immediately. Your payroll deductions will be cancelled, and you may be offered COBRA Continuation Coverage.

* Described under "Special Enrollment Rights" on the following page.

# Special Enrollment Rights

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

- You or one of your dependents loses other 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 and no later than the end of the next following Open Enrollment period, your new coverage will take effect the first day of the month after the Fund Office receives your enrollment.

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 420 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

# Additional Health Care and Death Benefits

If you are enrolled in the Indemnity PPO Medical Plan, the Benefit Fund automatically includes prescription drug, dental/orthodontic, vision coverage, podiatry benefits, and death benefits as well as EMAP benefits at no additional cost to you. Go to **scufcwfunds.com** and refer to your current *Silver/Gold Benefits* Chart for details.

## Prescription Drug Program

This program provides all of the Fund's prescription drug benefits for Participants and dependents enrolled in the Indemnity PPO Medical Plan. It covers part of the cost of medically necessary drugs prescribed by your physician.

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 copayment (copay), as shown in your current *Silver/Gold Benefits* Chart.

Copays vary depending on where you fill your prescription, whether you are participating in the Disease Management Program, and 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 (MPD) Program described on the next page
- 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.

### Participating Pharmacies

To receive prescription drug benefits, you must use a UFCW Unions and Food Employers Participating Pharmacy or Mail Service Pharmacy. 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 US and are staffed by pharmacists covered by collective bargaining agreements with the UFCW.

### Prescription Drug Out-of-Pocket Maximum

There is a separate Prescription Drug Out-of-Pocket Maximum that limits your share of costs for covered prescription drugs. Refer to your current Plan A Silver/Gold or Plan B Silver/Gold Benefits Chart for additional details. After the Prescription Drug Out-of-Pocket Maximum is reached, the Fund's Prescription Drug Program will pay 100% of the cost of the individual's or family's covered prescription drugs for the rest of the calendar year. Participant expenses for non-formulary brand-name drugs and Non-Preferred Drugs under the MPD Program do not count toward this Prescription Drug Out-of-Pocket Maximum. Prescription Drug Out-of-Pocket Maximums are subject to change every year based on ACA law.

If you wish to use your available HRA funds for prescription drug copay reimbursement, you must submit an *Rx-HRA Option Form* to the Fund. Forms are mailed to un-enrolled employees during Open Enrollment or following initial enrollment. If you have already submitted a form to the Fund, you do not have to submit another one. You may opt in for prescription drug reimbursement at any time, but you can opt out only during Open Enrollment. Visit **scufcwfunds.com** or contact the Fund Office or your Union Local if you need your *Rx-HRA Option Form*.

## Market Priced Drug Program

The Market Priced Drug (MPD) Program applies to everyone enrolled in the Indemnity PPO Medical Plan. 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 the 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 *Silver/Gold Benefits* 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.

# Dental/Orthodontic Benefits

The Fund's Dental Program helps you pay the cost of dental care for yourself and your covered dependents. You have a choice of two plans:

- The Indemnity Dental Plan, which allows you to use any dentist you like
- The Prepaid Dental Plan, under which you must choose a Prepaid Dental Center in Southern California and use only its dental professionals to receive benefits.

Both plans cover diagnostic, preventive and restorative dental services as shown in your current *Silver/Gold Benefits* Chart and described in the Fund's *Dental Program* booklet. Orthodontic benefits are also shown in your chart.

# Vision Care Program

Whether you need prescription eyeglasses or just an eye exam, the Vision Care Program will help you pay the cost of covered vision services for you and your enrolled dependents.

You may use any licensed vision care provider you like for exams and corrective eyeglasses or contact lenses. Benefits for corrective lenses and frames are payable as long as no more than 12 months have elapsed between the date of the last vision examination and the date the glasses or contact lenses are ordered, except when a lens change is required following eye surgery or other conditions. You pay any charges that exceed the maximum annual benefit shown in your current *Silver/Gold Benefits* Chart.

# Podiatry Services

To receive benefits for medically necessary podiatry services under the Indemnity PPO Medical Plan, you must receive care through the Podiatry Plan of California (PPOC). Benefits are subject to the Plan's medical Annual Deductibles, Coinsurance percentages, and benefit maximums. The Plan pays 75% of PPOC's contract rates after the medical Annual Deductible is satisfied. Podiatry services from non-PPOC providers are not covered.

To find a PPOC provider call 800-367-7762 or 415-928-7762 or go to **podiatryplan.com**.

# Death Benefits

The Fund provides all actively employed Silver and Gold Plan Participants with the following death benefits. Claims for death benefits must be made within one year of death.

- Upon your death:
  - A payment to your beneficiary of $11,250 to $13,500 depending on your years of service as shown in your current *Silver/Gold Benefits* Chart
  - A burial expense payment of $2,250, payable to your beneficiary or, if you have no beneficiary, to the person who presents evidence of payment for your burial expenses
- A payment of $3,000 to you upon the death of your eligible lawful spouse or eligible unmarried child/stepchild.

## Employee Accidental Death and Dismemberment Benefit (AD&D)

If you suffer a bodily injury caused by an external, violent accident that causes your death, the total loss of your sight in one or both eyes, loss of one or both hand(s) or loss of one foot or both feet within 90 days after the accident, the Fund will provide the following benefits:

- Upon your death your beneficiary will receive an accidental death payment equal to 100% of your death benefit as shown in your current *Silver/Gold Benefits* Chart
- If you lose the entire sight of one eye, or one hand, or one foot, you will receive a payment equal to 50% of your death benefit
- If you lose the entire sight of both eyes, both hands, both feet or any combination of these losses, you will receive a payment equal to 100% of your death benefit.

If you suffer more than one of the losses listed above from the accident, the Fund will pay only for the loss for which the largest amount is payable. The total accidental death and dismemberment benefit, payable from all causes, may not exceed the maximum amount to which you are entitled based on your completed years of service.

For the Death Benefit or AD&D Benefit claim to be considered, you must be enrolled and covered under the Indemnity PPO Medical Plan at the time of your death or accidental injury.

For the Death Benefit or AD&D Benefit claim to be considered, you must be enrolled and covered under the Indemnity PPO Medical Plan at the time of your death or accidental injury.

## 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 Designation* form, provided it is received in the Fund Office before your death. A beneficiary must be one or more natural persons or a trustee of a legally established trust for the benefit of one or more natural persons. You may download a *Beneficiary Designation* 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 to the first individual listed below who is living at the time of your death:

1. Your spouse
2. Your children
3. Your parents
4. Your siblings
5. If there are no such individuals living at the time of your death then, in lieu of a death benefit, the Plan will pay only the burial expense payment described above.

* Up to age 19 or between 19 and 24 provided they are full-time students or over age 19 and unemployable because of a physical or mental disability.

# Where to Get More Information

If you have questions or need more information about the benefits described in this booklet, contact your Union Local or call the Fund Office at the numbers listed below or visit the available websites.

| 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,<br>or 877-284-2320 | 6425 Katella Avenue<br>Cypress, CA 90630-5238<br>PO Box 6010<br>Cypress, CA 90630-0010 | scufcwfunds.com |
| **Participating Union Locals** | | | |
| **UFCW Local 8 – Bakersfield** | 661-391-5773<br>or 661-391-5770 | 1910 Mineral Ct.<br>Bakersfield, CA 93308 | ufcw8.org |
| **UFCW Local 135** | | | ufcw135.com |
| San Diego (Main Office) | 619-298-7772<br>or 800-545-0135 | 2001 Camino Del Rio South<br>San Diego, CA 92108 | |
| San Marcos | 619-298-7772<br>or 800-545-0135 | 323-A South Rancho Santa Fe Road<br>San Marcos, CA 92078 | |
| **UFCW Local 324** | | | ufcw324.org |
| Buena Park | 714-995-4601<br>or 800-244-8329 | 8530 Stanton Avenue<br>Buena Park, CA 90620 | |
| **UFCW Local 770** | | | ufcw770.org |
| Los Angeles (Main Office) | 213-487-7070<br>or 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 | |
| Huntington Park | 323-923-1510 | 5400 Pacific Boulevard<br>Huntington Park, CA 90255 | |
| Newhall | 661-259-9900 | 23030 Lyons Avenue, #102<br>Newhall, CA 91321-2720 | |
| 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 Boulevard,<br>Inglewood, CA 90301 | ufcw1442.org |
| **Health Care Plans** | | | |
| **Indemnity PPO Medical Plan:**<br>UFCW Unions and Food Employers Benefit Fund | 714-220-2297,<br>562-408-2715,<br>or 877-284-2320 | | scufcwfunds.com |
| **Anthem Blue Cross PPO Network** | | | anthem.com/ca |
| Hospital review/pre-authorization | 800-274-7767 | | |
| Find a PPO provider – California | 855-686-5613 | | |
| Find a PPO provider – Outside Calif. | 800-810-2583 | | |
| **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<br>or 415-928-7762 | | podiatryplan.com |