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United Food & Commercial Workers Unions and Food Employers Benefit Fund

Plan B Platinum Plus Benefits Chart for Calendar Year 2021

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 877-284-2320.

INDEMNITY PPO MEDICAL PLAN

HEALTH REIMBURSEMENT ACCOUNT (HRA) may be used only for medical plan deductibles, Participant[1] coinsurance on covered medical expenses, mental health/chemical dependency care expenses, and prescription drug copays. ("Opt in" for HRA reimbursement is required for prescription copays.) HRA funds cannot be used to pay vision expenses, dental/orthodontic expenses, penalties, disincentives, charges above the Plan's Allowed Amounts, or expenses that are not Covered Expenses. Unused funds are carried over to the subsequent year.

CALENDAR-YEAR HRA FUNDING	Single	Family with employee and children only	Family with employee and spouse/domestic partner with or without children
Automatic Base Contribution	$150	$425	$250
Maximum Earned Contribution	$575	$750	$925
Total HRA Funding Opportunity (Base + Earned)	$725	$1,175	$1,175
How to Earn HRA Contributions for 2021 through the My Health/My Choices Program	Complete certain health-related activities approved by the Fund between June 1, 2020, and May 31, 2021. "Healthy Activities" include completion of Health Risk Questionnaire (HRQ), annual flu shots, annual physical exams, health screenings, smoking cessation programs, weight loss programs, gym memberships, etc. Healthy Activities are each worth a $150 HRA contribution up to the maximums shown above. Program details are available at scufcwfunds.com/wellness/incentives and upon request from the Fund Office.		

PLAN FEATURES & BENEFITS	IN-NETWORK (PPO)	OUT-OF-AREA[2]	OUT-OF-NETWORK (NON-PPO)
Annual & Lifetime Maximum Benefit	None	None	None
Covered Charges	Allowed Amount for the applicable network (Blue Cross Prudent Buyer PPO, HMC, or Podiatry Plan, Inc.)	The Plan's Allowed Amounts are determined by the Fund. The Participant is responsible for charges that exceed Allowed Amounts. Charges in excess of Allowed Amounts are not payable from HRA funds.	
Annual Deductible[3]	$1,000 per person, $2,000 per family		$1,200 per person, $2,400 per family
Annual Medical Out-of-Pocket Maximum (includes deductible)[4]	$3,000 per person, $6,000 per family		None (except for emergency services)

[1] The term "Participant" includes "Dependent" where appropriate.

[2] Out-of-Area benefits pertain only to covered individuals who live where applicable Blue Cross Prudent Buyer PPO, HMC HealthWorks® (HMC), or Podiatry Plan, Inc. providers are not available.

[3] The covered charges that you pay each calendar year before the Plan begins to pay its benefits.

[4] Applies to covered charges subject to coinsurance; excludes expenses for outpatient prescription drugs, dental/orthodontic, vision care, and expenses in excess of benefit maximums.

Plan B Platinum Plus Benefits Chart for Calendar Year 2021

INDEMNITY PPO MEDICAL PLAN (Continued)			
PLAN FEATURES & BENEFITS	**IN-NETWORK (PPO)**	**OUT-OF-AREA**	**OUT-OF-NETWORK (NON-PPO)**
Plan Coinsurance	75% of Allowed Amount	75% of Allowed Amount	50% of Allowed Amount
Participant Coinsurance	25% of Allowed Amount	25% of Allowed Amount	50% of Allowed Amount
Preventive Care[1]	No deductible, Plan pays 100% of Allowed Amount		After deductible, Plan pays 50% of Allowed Amount
Family Planning[1]	FDA-approved generic contraceptive devices and female sterilization services are covered at **100% with no deductible**. The Plan pays **75% of covered charges after the deductible** for other family planning services. (Contraceptive drugs, if prescribed, are covered through the Prescription Drug Program.)		After deductible, Plan pays 50% of Allowed Amount
Emergency Care	After deductible, Plan pays 75% of covered charges		
• Covered Services	Emergency room, urgent care facility, ambulance		
Additional Accident Benefit	$400 for covered services rendered within 90 days of the accident. Plan will use accident benefit to reimburse deductible or out-of-pocket amounts before using available HRA funds.		
Chiropractic/Acupuncture Care	After deductible, Plan pays 75% of Allowed Amount, up to $1,000 per person per calendar year		
• Covered Services	Office visits, manipulations, modalities, adjustments, and x-rays.		
• Limitations	Only those services listed in the *Chiropractic/Acupuncture Schedule of Allowances* are covered. (Schedule is available online at scufcwfunds.com/healthcare/active-participants/chiropractic-careacupuncture/). There is a combined annual benefit limit for chiropractic/spinal manipulation, acupuncture, and acupressure services for each Participant.		
Hospital Services	After deductible, Plan pays 75% of Allowed Amount		After deductible, Plan pays 50% of Allowed Amount
• Covered Services	Inpatient services. Skilled nursing facility (benefit for room and board at non-PPO or out-of-area facility is limited to 50% of the semi-private room rate at the hospital from which patient was discharged). Alternative birthing center. Outpatient surgery.		
• Precertification Requirement	Automatically processed by provider	20% benefit reduction for non-compliance. Penalty cannot be paid from HRA funds.	
• Knee/Hip Joint Replacement Surgery	**Designated Hospital or out-of-area hospital:** After deductible, Plan pays 75% of covered charges.[2] **Non-designated PPO hospital:** After deductible, Plan pays 75% of the Allowed Amount, which is limited to $35,000 per confinement.[3]		After deductible, Plan pays 50% of covered charges based on an Allowed Amount of $35,000 per confinement.[3]
Outpatient Surgical Centers	After deductible, Plan pays 75% of Allowed Amount	After deductible, Plan pays 75% of Allowed Amount	After deductible, Plan pays 50% of Allowed Amount up to a maximum of $1,000[3]
• Precertification Requirement	Automatically processed by provider	There is a 20% benefit reduction penalty for non-compliance. Penalty cannot be paid from HRA funds.	
Physician and Other Health Care Professional Services	After deductible, Plan pays 75% of Allowed Amount		After deductible, Plan pays 50% of Allowed Amount
• Partial List of Covered Services	Physician office/home/hospital visits. Surgeon. Assistant surgeon. Anesthetist/anesthesiologist. Standby physician. Midwife. Chemotherapy & radiation. Physical/speech/inhalation therapy. Cardiac/pulmonary rehabilitation. Home health care/case management. Mastectomy/breast reconstruction. Hemodialysis. Registered nurse services/home nursing. Orthoptics. Lab & x-ray.		
• Limitations	If you use a Non-PPO Provider, TMJ surgical benefits are limited to $2,100 maximum per period of disability for non-PPO. Registered nurse services/home nursing limited to 400 visits per person per lifetime.		

[1] See the Plan's preventive care brochure at https://www.scufcwfunds.com/healthcare/active-participants/medical/ppo-plan/ for a description of covered services. Some services may not be covered when using an out-of-network provider.

[2] Go to https://www.scufcwfunds.com/healthcare/active-participants/medical/kneehip-replacement/ for a list of Designated Hospitals, and remember to call HMC at 844-751-4530 before selecting a hospital and scheduling surgery.

[3] You are responsible for any charges in excess of the Allowed Amount, and any such charges do not count toward the Plan's Annual Medical Out-of-Pocket Maximum.

INDEMNITY PPO MEDICAL PLAN (Continued)			
PLAN FEATURES & BENEFITS	**IN-NETWORK (PPO)**	**OUT-OF-AREA**	**OUT-OF-NETWORK (NON-PPO)**
Other Services	After deductible, Plan pays 75% of Allowed Amount		After deductible, Plan pays 50% of Allowed Amount
• Medical Supplies & Equipment, Drugs (except outpatient prescriptions)	Medical equipment and supplies such as durable medical equipment, oxygen and its administration, blood and blood products and their administration, medical prosthetics, splints, casts, other supplies, chemotherapy/radiation/antigens/infusion drugs and injectable drugs (except insulin, which is covered as other prescription drugs). For duration of breast feeding, one manual or electric pump (plus supplies) is provided at 100% without Deductible.		
• Limitations	Glucose home monitor – one device every two years. Orthopedic shoes – $235 annual maximum. Orthotics – $160 annual maximum. Hearing aids – $475 maximum for one aid or $785 maximum for two aids during any three-year period. Health aids (except crutches) – $120 annual maximum.		
Organ Transplants	After deductible, Plan pays 75% of Allowed Amount		After deductible, Plan pays 50% of Allowed Amount
• Limitations	The proposed transplant must be non-experimental and preauthorized, and the recipient must be a Plan Participant. The Plan will not cover expenses of the donor if the recipient is not a Plan Participant. The Plan will cover organ transplants at PPO, non-PPO, and Out-of-Area hospitals if both the recipient and the donor are Plan Participants. If the donor is not a Plan Participant, expenses of the donor that are incurred at a non-PPO hospital are not covered. Donor search fees are limited to $10,000 maximum per transplant.		
Podiatry Services	After deductible, Plan pays 75% of Allowed Amount		**NOT COVERED** If you need podiatry services, contact Podiatry Plan, Inc. at 800-367-7762 or 415-928-7762
• Covered Services	Physician office/home/hospital visits, surgeon.		
• Limitations	Services not authorized by Podiatry Plan, Inc. and rendered by Podiatry Plan, Inc. participating providers are not covered.		

INDEMNITY PPO MEDICAL PLAN EMPLOYEE MEMBER ASSISTANCE PROGRAM (EMAP) BENEFITS For Mental/Behavioral Health and Substance Abuse			
PLAN FEATURES & BENEFITS	**IN-NETWORK (PPO)**	**OUT-OF-AREA[1]**	**OUT-OF-NETWORK (NON-PPO)**
Annual & Lifetime Maximum Benefit	None	None	None
Covered Charges	In-network Allowed Amount for HMC providers.	The Participant is responsible for paying all charges that exceed the Allowed Amount. Charges above Allowed Amount are not payable from HRA funds.	
Annual Deductible	EMAP benefits are subject to the Annual Deductible		EMAP benefits are subject to the Annual Deductible
Annual Out-of-Pocket Maximum	EMAP benefits are subject to the Annual Medical Out-of-Pocket Maximum		None (except for emergency services)
Hospital/Rehab Facility Services	After deductible, Plan pays 75% of Allowed Amount	After deductible, Plan pays 75% of Allowed Amount	After deductible, Plan pays 50% of Allowed Amount
• Covered Services	Inpatient hospital and rehabilitation facilities. Includes all levels of facility care such as intensive outpatient and partial day care programs.		
• Precertification Requirement	Automatic when HMC coordinates the admission.	Precertification from HMC is required. There is a 20% benefit reduction for non-compliance. Penalty cannot be paid from HRA funds.	
• Day Maximum	None	None	None
Office Visits	After deductible, Plan pays 75% of Allowed Amount	After deductible, Plan pays 75% of Allowed Amount	After deductible, Plan pays 50% of Allowed Amount
Emergency Care	After deductible, Plan pays 75% of covered charges for an emergency medical condition		
• Covered Services	Emergency room, urgent care facility, ambulance		

[1] Out-of-Area mental/behavioral health and substance abuse benefits pertain only to covered individuals who live where HMC providers are not available.

Plan B Platinum Plus Benefits Chart for Calendar Year 2021

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)[1]				
HMO Participants are not eligible for Health Reimbursement Account (HRA) funding				
PLAN FEATURES & BENEFITS	**KAISER PERMANENTE HMO**	**ANTHEM™ BLUE CROSS HMO**		
Choice of Provider	You must receive all care from Kaiser providers and facilities. Unless noted otherwise below, care received from non-Kaiser providers is not covered except in an emergency.	You must choose between the Anthem™ Select HMO network and the Anthem™ Blue Cross HMO (CACare) network and each enrolled family member must have a PCP in the ***same*** network. Unless noted otherwise below, care received outside your chosen network is not covered except in an emergency.		
Lifetime Maximum Benefit	None	None		
Annual Maximum Benefit	None	None		
Covered Charges	Only services received from HMO providers are covered except in emergency situations			
Annual Deductible	None	None		
Annual Medical Out-of-Pocket Maximum[2]	$1,500 per person, $3,000 per family	$1,500 per person, $4,500 per family		
Copays	**KAISER PERMANENTE HMO**	**Anthem™ SELECT HMO Network**	**Anthem™ BLUE CROSS HMO (CACare) Network**	**If you live Outside the Anthem™ SELECT HMO Network Service Area[3]**
• Primary Care Physician (PCP) Office Visit	$25 per visit	$25 per visit	$35 per visit	$25 per visit
• Specialist Office Visit	$35 per visit	$35 per visit	$45 per visit	$35 per visit
• Urgent Care	$25 per visit	$50 per visit	$70 per visit	$50 per visit
• Emergency Room Visit (copay waived if admitted)	$100 per visit	$100 per visit	$150 per visit	$100 per visit
• Outpatient Surgery	$150 per procedure	$150 per procedure	$200 per procedure	$150 per procedure
• Hospital Services	$500 per admission	$500 per admission	$750 per admission	$500 per admission
Other Services	Family planning, preventive care, podiatric care, medical equipment and supplies, and hearing aids are provided through the HMO			
Acupuncture/Chiropractic Care	Provided through the Fund. Plan pays 100% of Allowed Amount after $25 copay for office visits, or 75% of Allowed Amount for x-ray/lab. Only those services listed in the scufcwfunds.com/healthcare/active-participants/chiropractic-careacupuncture/ are covered. $1,000 per person annual maximum combined for all services.			
Injectables (except insulin)	Provided through the Kaiser HMO. If not covered by the Kaiser HMO, paid by the Fund at 75% of Allowed Amount. After Ancillary Benefits Out-of-Pocket Maximum is met, covered injectables are paid by the Fund at 100% of Allowed Amount.	Provided through Anthem™ Blue Cross HMO. If not covered by the Anthem™ Blue Cross HMO, paid by the Fund at 75% of Allowed Amount. After the Annual Medical Out-of-Pocket Maximum is met, covered injectables are paid at 100% of Allowed Amount.		
Ancillary Benefits Out-of-Pocket Maximum	There is an Ancillary Benefits Out-of-Pocket Maximum of $2,500 per person per calendar year. This out-of-pocket maximum applies to the portion of Allowed Amounts you pay for covered injectables, plus the copays or portion of Allowed Amounts that you pay for Acupuncture and Chiropractic Care. After this out-of-pocket maximum is met, covered Ancillary Benefits are paid at 100% of the Allowed Amount for the remainder of the calendar year.	The Anthem™ Blue Cross HMO does not have a separate Ancillary Benefits Out-of-Pocket Maximum. The copay or the portion of the Allowed Amount that you pay for all ancillary benefits, such as Injectables, Acupuncture or Chiropractic care, accumulates to the Annual Medical Out-of-Pocket Maximum listed above. After the Annual Medical Out-of-Pocket Maximum is met, covered services are paid at 100% of Allowed Amount for the remainder of the calendar year.		

[1] Refer to each HMO's booklets for coverage details. To enroll in the Anthem™ Blue Cross HMO or Kaiser, you must ***live*** in its service area.
[2] Applies to medical, mental/behavioral health, and substance abuse services combined. Prescription drug copays do not count toward your Annual Medical Out-of-Pocket Maximum. Prescription drug coverage for HMO Participants is provided through the Benefit Fund's Prescription Drug Program.
[3] The Anthem™ Select HMO Network copays apply to Participants who do not have access to Anthem™ Select HMO network providers because they live outside the service area of the Anthem™ Select HMO Network.

MENTAL/BEHAVIORAL HEALTH AND SUBSTANCE ABUSE

PLAN FEATURES & BENEFITS	KAISER PERMANENTE HMO	ANTHEM™ BLUE CROSS HMO/HMC EMAP		
Choice of Provider	Only services received from Kaiser Permanente providers are covered except in emergency situations.	Provided through EMAP administered by HMC. Only services received from HMC providers are covered except in emergency situations.		
Copays		**Anthem™ SELECT HMO**	**Anthem™BLUE CROSS HMO (CACare)**	**Outside the Anthem™ SELECT HMO Area[2]**
• Hospital/Rehab Facility Services	$500 per admission	$500 per admission		
• Office Visits				
○ Per individual visit with a counselor or Ph.D. (e.g., psychologist)	$25	$25	$25	$25
○ Per individual visit with M.D. (e.g., psychiatrist)	$25	$25	$35	$25
○ Per group session	$12	$12.50	$12.50	$12.50
• Emergency Room Visit	$100 per visit (waived if admitted)	$100 per visit (waived if admitted)		

PRESCRIPTION DRUGS You *must* fill your prescriptions at a Participating Pharmacy or there is no coverage available. The only exception to this is coverage for certain emergency situations. For a complete list of all Participating Pharmacies visit optumrx.com

("Opt in" for Indemnity PPO Medical Plan HRA reimbursement is required.)

Annual Deductible	None
Annual Prescription Drug Out-of-Pocket Maximum	**Indemnity PPO Medical Plan: $5,550** per person, **$11,100** per family[1] **Kaiser Permanente HMO: $7,050** per person, **$14,100** per family[1] (includes charges applied to Ancillary Benefits Out-of-Pocket Maximum-see page 4) **Anthem™ Blue Cross HMO: $7,050 per person, $12,600 per family**[1]
Available Supplies/Pharmacies	Up to a 90-day supply per prescription from any UFCW Participating Network Pharmacy or from the OptumRx Mail Service Pharmacy

Market Priced Drug Program (MPD) Drugs

Certain drugs for treating common health conditions are covered through the Market Priced Drug Program (MPD). Under the MPD, lower cost drugs are called "Preferred Drugs." Drugs that are not on the Preferred Drug list are called "Non-Preferred Drugs." **Your cost for a Non-Preferred Drug will be much higher than the copay for a Preferred Drug.**

YOUR COST PER PRESCRIPTION FOR A PREFERRED MPD DRUG			YOUR COST PER PRESCRIPTION FOR A NON-PREFERRED DRUG
Type of Medication	**Up to 30-Day Supply**	**90-Day Supply**	
• Formulary MPD Generic Drug	$10 copay	$20 copay	**OR** You pay the copay listed to the left **PLUS** the actual difference in price between the Non-Preferred Drug and the Preferred Drug, if applicable. **Always ask your pharmacist to verify your cost for every prescription before it is filled.**
• Formulary MPD Brand-Name Drug	$25 copay	$50 copay	
• Non-Formulary MPD Drug	$40 copay	$80 copay	

[1] Copays included in the Annual Prescription Drug Out-of-Pocket Maximum are those for formulary generic drugs, formulary brand-name drugs, Preferred MPD drugs, and non-formulary drugs approved due to medical exceptions. Your cost for MPD Non-Preferred drugs, and for non-formulary drugs that have not been approved by the Fund's pharmacy benefits manager for a medical exception, do not count toward the Annual Prescription Drug Out-of-Pocket Maximum, and will not be paid by the Plan at 100% in the event that you reach your Prescription Drug Out-of-Pocket Maximum.

PRESCRIPTION DRUGS (Continued) ("Opt in" for Indemnity PPO Medical Plan HRA reimbursement is required.)

Non-MPD Prescription Drugs

The copays listed in this section apply to drugs that are not included in the MPD.

YOUR COST PER PRESCRIPTION

Type of Medication	Up to 30-Day Supply	90-Day Supply
• Formulary Generic Drug[1]	$10 copay	$20 copay
• Formulary Brand-Name Drug	$25 copay	$50 copay
• Non-Formulary Drug	$40 copay	$80 copay

ALWAYS ASK YOUR PHARMACIST TO VERIFY YOUR COST FOR EVERY PRESCRIPTION ***BEFORE*** IT IS FILLED.

Contact the Fund Office if you have any questions about your prescription drug benefits.

Special Therapeutic Classes

The reduced copays listed in this section are for maintenance medications to treat hypertension, high cholesterol, diabetes (control drugs and supplies), osteoporosis, glaucoma, and asthma (including related supplies). **The following reduced copays apply to Non-MPD drugs and drugs that are on the MPD "Preferred Drug" list. If your prescription is filled with a drug that is classified as "Non-Preferred" under the MPD program, your cost will be much higher than the copays for the special therapeutic classes shown below because you will be responsible for paying the difference in price between the Non-Preferred Drug and the Preferred Drug as well as the applicable copay.**

YOUR COST PER PRESCRIPTION FOR A NON-MPD DRUG OR A PREFERRED MPD DRUG			YOUR COST PER PRESCRIPTION FOR A NON-PREFERRED DRUG
Type of Medication	**Up to 30-Day Supply**	**90-Day Supply**	
• Formulary Generic Drug	$7 copay	$14 copay	**OR** You pay the copay listed to the left **PLUS** the actual difference in price between the Non-Preferred Drug and the Preferred Drug, if applicable.
• Formulary Brand-Name Drug	$15 copay	$30 copay	
• Non-Formulary Drug	$25 copay	$50 copay	

Participant-submitted Claims

Available only for emergencies and out-of-area users. Plan pays the lesser of purchase price or average wholesale price (AWP) less applicable copay(s). There is an additional copay of $25 for each emergency prescription filled at a non-network pharmacy. Amounts over AWP cannot be paid from HRA funds.

SUMMARY OF OUT-OF-POCKET MAXIMUMS FOR CALENDAR YEAR 2021

MEDICAL PLAN OPTION:	INDEMNITY PPO MEDICAL PLAN		KAISER PERMANENTE HMO		ANTHEM™ BLUE CROSS HMO	
ANNUAL MEDICAL OUT-OF-POCKET MAXIMUM	Individual	Family	Individual	Family	Individual	Family
	$3,000	$6,000	$1,500	$3,000	$1,500	$4,500
• Included Expenses	Deductibles and coinsurance for medical, mental/behavioral health, and substance abuse services combined[2]		Copays for medical and Kaiser Permanente mental/behavioral health and substance abuse services combined		Copays for medical and HMC EMAP mental/behavioral health and substance abuse services combined	
• Excluded Expenses	Dental/orthodontic expenses, vision care expenses, prescription drug expenses, charges above the Plan's Allowed Amount, the additional deductible under the Disease Management Program, charges in excess of benefit maximums, penalties for non-compliance, and charges from non-PPO providers		Dental/orthodontic expenses, vision care expenses, prescription drug expenses, and charges from non-Kaiser Permanente providers[3]		Dental/orthodontic expenses, vision care expenses, prescription drug expenses, and charges from non-Anthem™ Blue Cross HMO or non-HMC providers[3]	

[1] Some generic preventive and contraceptive drugs are covered 100% with no copay. See the Plan's preventive care brochure at https://www.scufcwfunds.com/healthcare/active-participants/medical/ppo-plan/ for a description of these covered prescription drugs or request a copy from the Fund Office or your Union Local

[2] Network providers must provide services unless you are eligible for "Out-of-Area" benefits or if the services are necessary for emergency care.

[3] Your cost for services from non-HMO or non-HMC providers is included only if the services are necessary for emergency care.

SUMMARY OF OUT-OF-POCKET MAXIMUMS FOR CALENDAR YEAR 2021 (Continued)						
MEDICAL PLAN OPTION:	**INDEMNITY PPO MEDICAL PLAN**		**KAISER PERMANENTE HMO**		**ANTHEM™ BLUE CROSS HMO**	
ANNUAL PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM	**Individual**	**Family**	**Individual**	**Family**	**Individual**	**Family**
	$5,550	**$11,100**	**$7,050**	**$14,100**	**$7,050**	**$12,600**
• Included Expenses	Copays for formulary generic drugs, formulary brand-name drugs, Preferred MPD drugs, and non-formulary drugs approved due to medical exceptions					
• Excluded Expenses	Your cost for MPD Non-Preferred drugs, non-formulary brand-name drugs that have not been approved by the Fund's pharmacy benefits manager for a medical exception, and certain specialty drugs					
Note: Prescription drug benefits for all medical plan options are provided under the Fund's Prescription Drug Program summarized on the previous page.						

DENTAL/ORTHODONTIC CARE (Indemnity PPO Medical Plan HRA funds cannot be used for dental/orthodontic expenses.)		
DENTAL	**INDEMNITY DENTAL PLAN[1]**	**PREPAID DENTAL PLAN**
Annual Deductible	$50 per person, $150 per family (waived for preventive and diagnostic procedures)	None
Annual Benefit Maximum		
• Ages 0-18	None	None
• Ages 19 and up	$1,400 per person[2]	None
Limitations	Only services listed in the Dental Schedule of Allowances are covered. The schedule is available at https://www.scufcwfunds.com/healthcare/active-participants/dentalorthodontic-care/ and from the Fund Office.	
Plan Payment	Preventive/Diagnostic: 100% of Allowed Amount Basic Restorative: 80% of Allowed Amount Major Restorative: 70% of Allowed Amount **The Participant is responsible for the full cost of services not on the Dental Schedule of Allowances.**	100% after required Participant copays. Copays: Crown/pontics $75; prosthodontics $100; endodontics $45 anterior, $90 bicuspid, $125 molar. **The Participant is responsible for the full cost of services not on the Dental Schedule of Allowances.**
ORTHODONTIC	**NETWORK PANEL ORTHODONTISTS[3]**	**NON-PANEL ORTHODONTISTS**
Plan Payment	100% of negotiated rate after the Participant's portion is paid	75% of Allowed Amount
Benefit Maximum	$1,500 per person per lifetime	$1,500 per person lifetime
Participant Responsibility	Up to $1,200 per person based on the services provided[3]	Balance of provider's fee for service after Plan payment
Important note: Dental/orthodontic benefits are automatically included with medical coverage at ***no additional cost to you***. You may opt-out by calling the Fund Office and completing the proper form. Dropping your dental/orthodontic coverage ***will not reduce your weekly payroll deductions.***		

[1] If the total charges are expected to be more than $500, we recommend that your dentist's proposed treatment plan be submitted to the Fund for review so that dental benefits can be preauthorized.

[2] Unused dental benefits, up to one half of the annual benefit maximum, will carry over to the following calendar year. The maximum carryover for dental expenses in any given calendar year is $700

[3] Patients who obtain care through a network panel orthodontist are also responsible for the following expenses: the cost of special diagnostic records in excess of the Plan's Allowed Amount, lost or broken appliance(s), missed appointments or cancellations made without 24-hour notice, cost of treatment obtained elsewhere should patient not cooperate with panel orthodontist, and cost of treatment that extends past 30 months due to the patient's failure to cooperate with panel orthodontist. Call the Fund Office to locate a network panel orthodontist near you.

VISION CARE (Indemnity PPO Medical Plan HRA funds cannot be used for vision expenses.)	
• Ages 0-18	Plan pays up to $125 per child per calendar year. The $125 annual limit does not apply to essential pediatric services such as vision screenings and exams. Any additional charges, including those for frames and lenses, are subject to the annual dollar maximum regardless of age.
• Ages 19 and up	Plan pays up to $125 per person per calendar year for exam and materials[1].

Important notes:

- Vision benefits are automatically included with medical coverage at ***no additional cost to you***. You may opt-out by calling the Fund Office and completing the proper form. Dropping your vision coverage ***will not reduce your weekly payroll deductions.***
- Payment for prescription lenses will be made only if no more than 12 months have elapsed between the date of the last vision examination and the date glasses or contact lenses are ordered, except when a lens change is required following eye surgery or other conditions.

DEATH BENEFITS	Employee Death Benefit[2]	Dependent Death Benefit	Burial Expense[3]
Plan Payment	$11,250 – $22,500 Depending on Years of Service[4] as follows: ▪ Up to 6 years: $11,250 ▪ 6 but less than 7 years: $13,500 ▪ 7 but less than 8 years: $15,750 ▪ 8 but less than 9 years: $18,000 ▪ 9 but less than 10 years: $20,250 ▪ 10 or more years: $22,500	$3,000 For enrolled lawful spouse; enrolled unmarried children/stepchildren 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.	Maximum of $2,250 (in lieu of Employee Death Benefit, where no eligible beneficiary)

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT[2]	
Accidental Death and Dismemberment Benefit percentages are payable if an employee's bodily injury is effected solely through external, violent, and accidental means and results in any of the losses listed below within 90 days after the date of the accident causing the loss. If you suffer more than one of the losses listed below 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.	
Employee's loss of the entire sight of one eye, or the loss of one hand or one foot	50% of the applicable Employee Death Benefit
Employee's loss of the entire sight of both eyes; or the loss of both hands or both feet; or the loss of one hand and one foot; or the loss of one hand or one foot together with the sight of one eye; or loss of life[5]	100% of the applicable Employee Death Benefit

[1] Unused vision benefits, up to one half of the annual benefit maximum, will carry over to the following calendar year. The maximum carryover for vision expenses in any given calendar year is $62.50.

[2] Claim must be received or postmarked within one year of death or accidental dismemberment.

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

[4] Years of Service without a Break in Service of 12 consecutive months or longer with no work in Covered Employment. A Break in Service results in the loss of all prior Years of Service. Contact the Fund Office for types of absences that excuse a Break in Service.

[5] Where loss of life occurs, the 100% Accidental Death and Dismemberment Benefit is payable in addition to the Employee Death Benefit amount outlined above

EXCLUDED SERVICES AND LIMITATIONS

GENERAL EXCLUDED SERVICES AND LIMITATIONS

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

The Benefit Fund does not pay benefits for the following:

- Services or supplies that are not medically necessary unless specifically covered under the Plan, such as preventive care benefits
- Experimental or investigative services, supplies, procedures, treatments, or drugs, except as required under the federal Affordable Care Act for clinical trials
- Expenses directly related to a non-covered procedure, service, treatment, supply, or drug
- Services provided by an immediate relative of an eligible Participant or by members of a Participant's household, except for covered expenses that are out-of- pocket expenses to the providers (the term "immediate relative" means spouse or domestic partner, child, parent, sibling, parent of current spouse or domestic partner, or grandparent)
- Conditions covered by Workers' Compensation or arising out of or in the course of any employment or self-employment
- Injuries resulting from any form of warfare or invasion or while on active duty with the armed forces
- Charges incurred while the patient's coverage is not in effect
- Services or supplies for which there is no charge or liability to pay
- Services or supplies furnished by or for the United States government or any other government, unless payment is legally required
- Any portion of expenses provided under any governmental program or law under which the individual is or could be covered
- Any service or supply furnished by a hospital or facility run by the federal government or other authorized agency, or at the expense of such agency or facility, except as required by federal law
- Charges in excess of covered charges (for example, charges that exceed Allowed Amounts as determined by the Fund)
- Claims submitted more than one year after the date a covered charge is incurred
- Educational services, supplies, or equipment, including, but not limited to, computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, auditory or speech aids/synthesizers, auxiliary aids, communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading, or self-esteem, etc., special education and associated costs in conjunction with tactile systems like Braille or sign language education for a patient or family members, and implantable medical identification/tracking devices.

INDEMNITY PPO MEDICAL PLAN

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

- Services or supplies not prescribed, recommended, or approved by a physician
- Services or supplies that are not medically necessary for the treatment of an illness or injury, unless specifically covered under the Plan, such as preventive care benefits and sterilization procedures
- Treatment of infertility, except for the initial exam and diagnostic services

EXCLUDED SERVICES AND LIMITATIONS (Continued)

INDEMNITY PPO MEDICAL PLAN (Continued)

- Services to reverse voluntary surgically induced infertility
- Personal items provided in a hospital
- Cosmetic procedures, except surgery to repair damage caused by accidental bodily injury, breast reconstruction following a mastectomy, or restorative surgery performed during or following mutilative surgery required as a result of illness or injury
- Expenses incurred by an organ donor, unless the recipient of the organ is a Participant in the Indemnity PPO Medical Plan
- Expenses incurred at an out-of-network hospital by an organ donor, unless the donor and the recipient are both Participants in the Indemnity PPO Medical Plan
- Custodial care and homemaker services
- Vocational training
- Ambulance services for transportation only to suit the patient's or physician's convenience
- Paramedic services when the patient is not transported to a hospital
- Podiatric treatment by a podiatrist who is not affiliated with Podiatry Plan, Inc.
- Treatment of mental health disorders or substance abuse (these may be covered under the EMAP or the Kaiser HMO)
- Treatment directly on or to teeth or gums, including tumors (these may be covered under the Dental Program)
- Charges that are used to satisfy the Annual Deductible
- Dependent child maternity charges (except as required under the Preventive Care Guidelines determined by the federal Affordable Care Act)
- Tobacco cessation programs (except as required under Preventive Care Guidelines determined by the federal Affordable Care Act)
- Weight loss programs (except as required under Preventive Care Guidelines determined by the federal Affordable Care Act)
- Physical fitness programs or club memberships
- Surrogate pregnancies and all related charges, both when the surrogacy is for a Plan Participant and when a Plan Participant is the surrogate

PRESCRIPTION DRUGS

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

- Prescriptions dispensed by a licensed hospital during confinement, except for drugs dispensed by the hospital pharmacy for "take-home" medication in emergency circumstances
- Drugs, medications, or non-drug items that may be purchased without a doctor's written prescription, except that diabetic supplies are covered
- Contraceptive devices (these may be covered under the Indemnity PPO Medical Plan) and over-the-counter contraceptive drugs or methods, unless a prescription is presented, and the drug or method is covered under the Plan's preventive care benefits
- Injectable immunization agents (these may be covered under the Indemnity PPO Medical Plan)
- Injectable drugs administered or dispensed by a physician (or administered by a nurse), except for injectables used for chemotherapy and Depo-Provera (these may be covered under the Indemnity PPO Medical Plan)
- Drugs used to promote hair growth
- Drugs used for the treatment of infertility
- Drugs that induce abortion
- Drugs that are not medically necessary for the treatment of an illness or injury, except as specifically provided, such as oral contraceptives

EXCLUDED SERVICES AND LIMITATIONS (Continued)

PRESCRIPTION DRUGS (Continued)

- Appliances or prosthetics (these may be covered under the Indemnity PPO Medical Plan)
- Lost, stolen, broken, or spilled supplies or prescription drugs
- Services otherwise provided under the Indemnity PPO Medical Plan
- Tobacco cessation medications (except as required under Preventive Care Guidelines determined by the federal Affordable Care Act)

DENTAL/ORTHODONTIC CARE

Refer to EXCLUSIONS AND LIMITATIONS in the Fund's Dental Program booklet.

VISION CARE

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

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

HMC EMAP BENEFITS

In addition to THE GENERAL EXCLUDED SERVICES AND LIMITATIONS, the EMAP does not pay for:

- Services otherwise provided under the Indemnity PPO Medical Plan
- Court-ordered services, except those that HMC would have deemed clinically necessary and appropriate were the court not involved

HMO MEDICAL BENEFITS

Refer to the EXCLUSIONS AND LIMITATIONS listed in the HMO's Evidence of Coverage.

This is only a brief summary of Plan benefits. Not all provisions, limitations and exclusions have been included. Contact the Benefit Fund Office for additional information.

WHERE TO GET MORE INFORMATION

For more information about the benefits described in this summary, call the Fund Office, contact your Union Local, or visit their websites.

ORGANIZATION	PHONE NUMBER	STREET ADDRESS	WEBSITE
Southern California United Food & Commercial Workers Unions and Food Employers Joint Benefit Funds Administration, LLC	**877-284-2320**	**6425 Katella Avenue, Cypress, CA 90630-5238 P.O. Box 6010, Cypress, California 90630-0010**	**scufcwfunds.com**
PARTICIPATING UNION LOCALS			
UFCW Local 8 — Bakersfield	661-391-5773 or 661-391-5770	1910 Mineral Ct., Bakersfield, CA 93308	**ufcw8.org**
UFCW Local 135			**ufcw35.com**
San Diego	619-298-7772 or 800-545-0135	2001 Camino Del Rio South, San Diego, CA 92108	
San Marcos	619-298-7772 or 800-545-0135	323-A South Rancho Santa Fe Road, San Marcos, CA 92078	
UFCW Local 324—Buena Park	714-995-4601 or 800-244-8329	8530 Stanton Avenue, Buena Park, CA 90620	**ufcw324.org**
UFCW Local 770			**ufcw770.org**
Los Angeles (Main Office)	213-487-7070 or 800-832-9770	630 Shatto Place, Los Angeles, CA 90005	
Arroyo Grande	805-481-5661	140 W. Branch Street, Arroyo Grande, CA 93420	
Camarillo	805-383-3300	816 Camarillo Springs Road, Suite H, Camarillo, CA 93012	
Harbor City	310-784-5340	25949 Belle Porte Avenue, Harbor City, CA 90710	
Huntington Park	323-923-1510	5400 Pacific Boulevard, Huntington Park, CA 90255	
Santa Barbara	805-681-0770	4213 State Street, Suite 201, Santa Barbara, CA 93110	
Santa Clarita	661-259-9900	27125 Sierra Highway, Suite 204, Santa Clarita, CA 91351	
UFCW Local 1167 — Bloomington	909-877-1110	855 West San Bernardino Avenue, Bloomington, CA 92316	**ufcw1167.org**
UFCW Local 1428 — Claremont	909-626-6800	705 West Arrow Highway, Claremont, CA 91711	**ufcw1428.org**
UFCW Local 1442 — Inglewood	310-322-8329	9075 S. La Cienega Boulevard, Inglewood, CA 90301	**ufcw1442.org**
HEALTH CARE PLANS	**PHONE NUMBER**	**WEBSITE**	
Indemnity PPO Medical Plan: UFCW Unions and Food Employers Benefit Fund	877-284-2320	**scufcwfunds.com**	
Anthem™ Blue Cross PPO Networks		**anthem.com/ca**	
Hospital review/pre-authorization	800-274-7767		
Find a PPO provider — California	855-686-5613		
Find a PPO provider — Outside California	800-810-2583		
Anthem™ Blue Cross HMO	800-227-3771	**anthem.com/ca**	
Kaiser Permanente HMO	800-464-4000	**kp.org**	
OptumRx	888-715-7573	**optumrx.com**	
HMC Employee Member Assistance Program (EMAP)	800-461-9179	**hmchealthworks.com**	
Podiatry Plan, Inc.	800-367-7762 or 415-928-7762	**podiatryplan.com**	