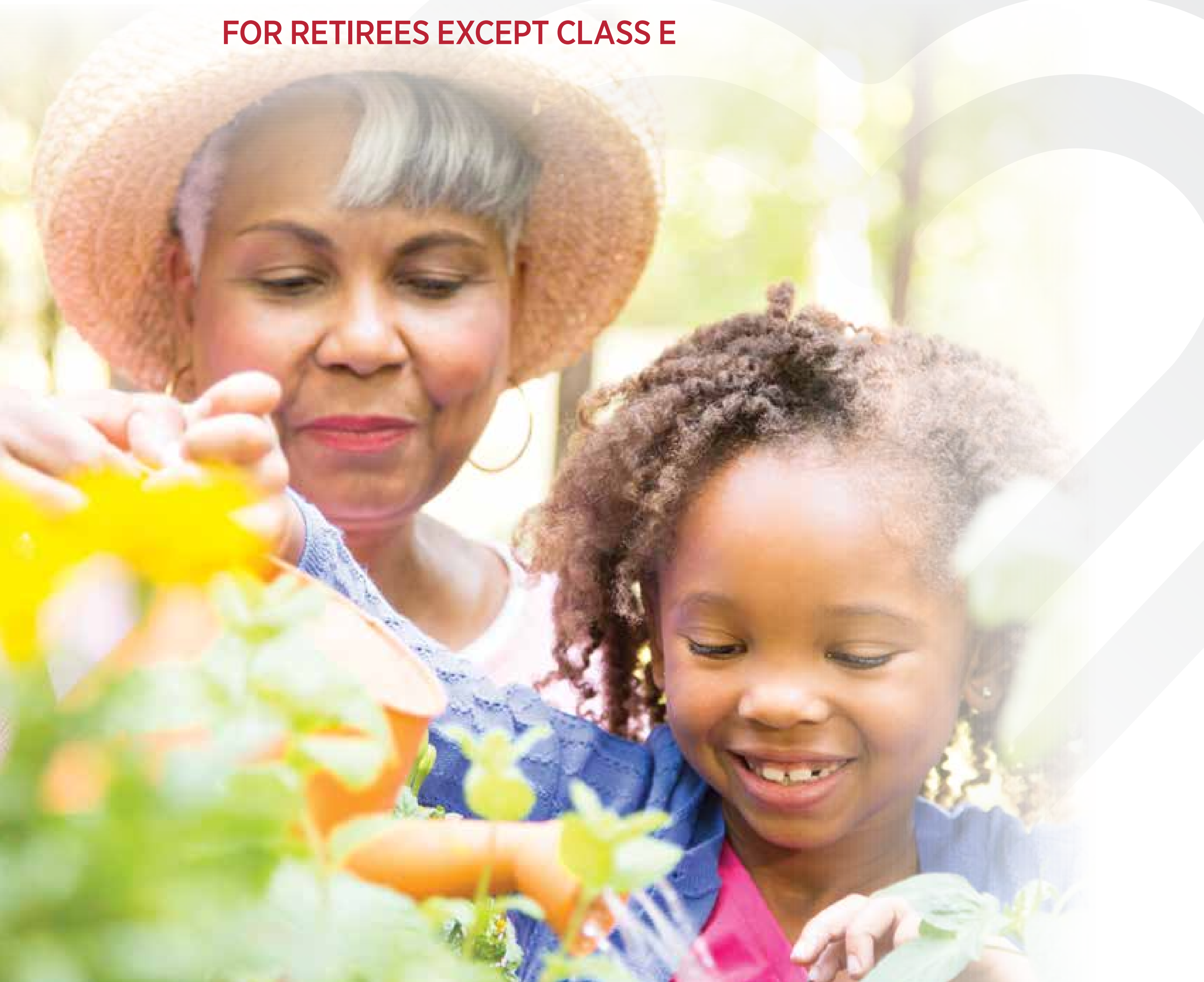
Benefits+
Your Trusted Health Care Partner

United Food & Commercial Workers Unions
and Food Employers Benefit Fund

Medical Benefit Highlights

FOR RETIREES EXCEPT CLASS E



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Esta publicación contiene información importante acerca de sus beneficios. Si usted tiene dificultad para comprender cualquier parte de esta información, o si tiene preguntas, comuníquese con su sindicato local o con la oficina del Fondo al 877-284-2320.

About this Booklet

This booklet provides a brief summary of some of the health and welfare benefits available to retirees through the United Food & Commercial Workers Unions and Food Employers Benefit Fund (the "Fund"). **The Plan limits benefits for certain medical services and supplies. Refer to your current *Retiree (Except E) Benefits Chart* for more details about the benefits provided under the Retiree Plan.**

Whether you are already retired or planning to retire, this booklet and other materials you receive from the Fund can help you make enrollment and health care decisions that best meet your needs and the needs of your family. This booklet also contains information about eligibility for benefits and how to pay for your retiree health care coverage. Please read page 7 for important information about the requirement to enroll in Medicare Parts A and B, and how to protect your Plan benefits.

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

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

Where to Get More information

Please refer to your current *Retiree (Except E) Benefits Chart* and other materials provided by the Fund to learn more about the benefits available to retirees and their eligible dependents.

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

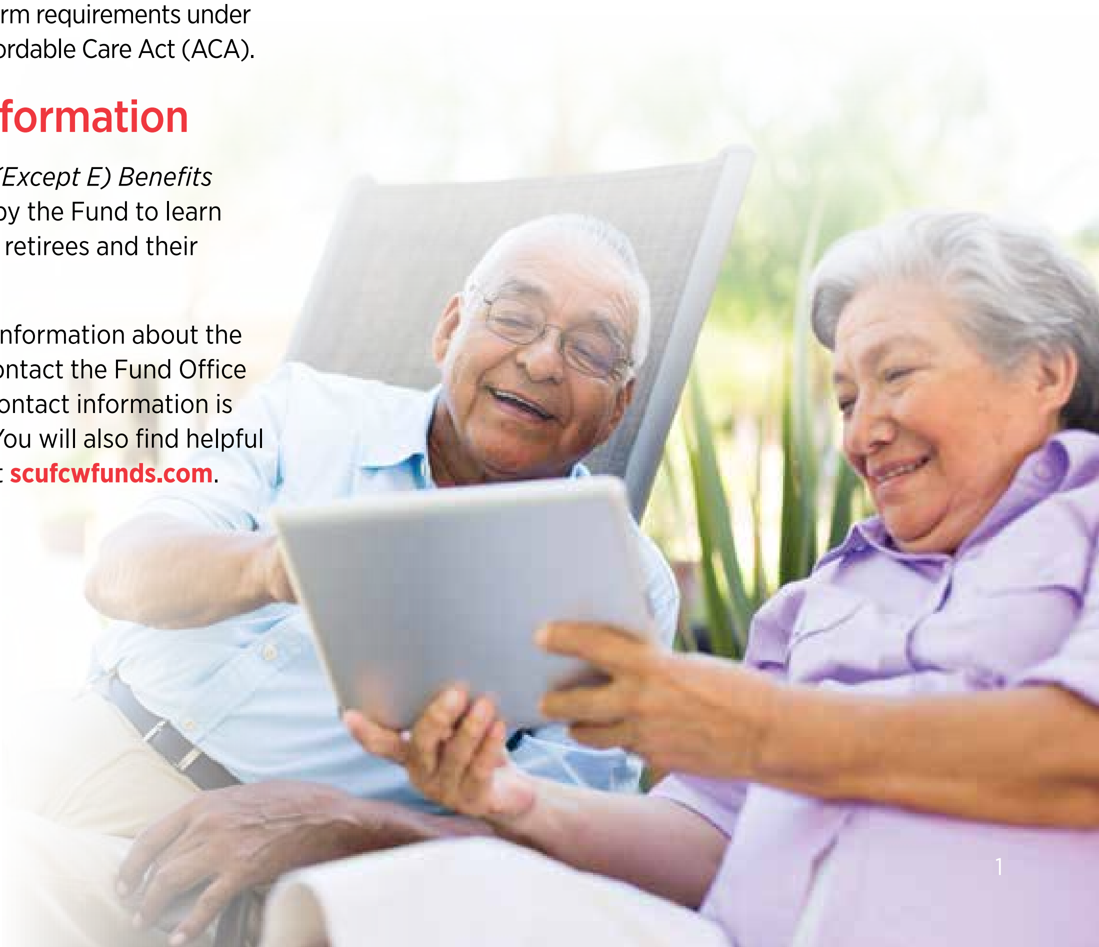
You may contact the Fund personally by visiting its office at:

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

The Fund Office mailing address is:

Southern California United Food & Commercial Workers Unions and Food Employers Joint Benefit Funds, LLC
PO Box 6010
Cypress, CA 90630-0010

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



Eligibility for Retiree Health and Welfare Benefits

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

How Your Eligibility is Determined

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

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

When Retiree Coverage Begins

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

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

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

Health Care Benefits Overview

Medical Coverage

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

Retiree medical plan options vary depending on where you live and your Medicare status. If you live in a Southern California area served by the HMOs offered by the Fund, medical plans that may be available to you are:

- The Fund's Indemnity PPO Medical Plan (Medicare and non-Medicare benefits)
- Kaiser plans: Kaiser Permanente HMO (non-Medicare) or Kaiser Permanente Senior Advantage (a Medicare Advantage HMO)
- Anthem™ plans: Anthem™ Blue Cross HMO (non-Medicare) or Anthem™ Medicare Preferred PPO (a Medicare Advantage PPO)

You must live in the HMO's service area to enroll in that HMO. If you live outside a Fund-sponsored HMO service area, the Indemnity PPO Medical Plan is the only option available to you if you are not eligible for Medicare. If you are eligible for Medicare, you may choose between the Indemnity PPO Medical Plan and the Anthem™ Medicare Preferred PPO.

Retirees and their dependents must be enrolled in the same plan. For example, if the Retiree enrolls in the Indemnity PPO Medical Plan, the retiree's dependents must also be enrolled in the Indemnity PPO Medical Plan. If the Retiree elects Kaiser Senior Advantage, then the dependents must be covered under the corresponding Kaiser plan (Medicare or non-Medicare). See page 16 for additional information on HMO plan options, based on Medicare eligibility status. Retirees and Dependents who are eligible for Medicare MUST enroll in Medicare Part A and Part B.

To compare the major features of the medical plans available to retirees and their dependents, refer to your current *Retiree (Except E) Benefits Chart*.

Vision Coverage

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

Dental Coverage

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

- The Indemnity Dental Plan
- The Prepaid Dental Plan.

Dependents of retirees who are enrolled in one of the Fund's retiree dental plans are automatically eligible for dental benefits through the Plan, even if they are not enrolled in your medical plan.

Additional Benefits Under the Medical Plans

The Fund's Indemnity PPO Medical Plan and the HMO Plans provide additional benefit programs. See the chart below for details.

Medical Plans Providing Additional Health Care Benefits

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

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

Monthly Costs

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

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

The amount you pay for retiree medical coverage depends on whether you elect to cover your spouse/registered domestic partner, and your or your spouse/registered domestic partner's (if applicable) enrollment in Medicare.

If you choose to enroll only yourself, or yourself and your eligible dependent children, you will pay the single rate.

If you choose to enroll your eligible spouse/domestic partner, you will pay the family rate, regardless of whether you also enroll your dependent children.

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

Authorized Pension Deductions

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

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

Your pension deductions or monthly payments for health care coverage will be adjusted automatically for any increase to your monthly cost, unless you disenroll from the Plan.

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

Late Payment and Loss of Coverage

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

Failure to make your required payments on time can result in a loss of coverage for up to three years. Please see page 18 for additional information on loss of coverage.

EXAMPLE

If your coverage ended March 31, 2021, you cannot re- enroll until the Open Enrollment in 2023 for coverage effective January 1, 2024.

Enrollment

Upon Retirement

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

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

For medical benefits, you may choose between single and family coverage.

Retiree Medical Plan Coverage Options

Provider	Retiree		Dependent(s)	
	Non-Medicare	Medicare	Non-Medicare	Medicare
Fund's Indemnity PPO Medical Plan	Available to retirees and dependents, regardless of Medicare status. (This is not a Medicare Supplement Plan. Benefits are coordinated with Medicare Part A and Part B for covered individuals who are eligible for Medicare. Covered charges are the lesser of the Medicare Allowed Amount, the PPO contract rate, or the Plan's Allowed Amount)			
Anthem™ Plans	Anthem™ Blue Cross HMO	Anthem™ Medicare Preferred PPO	Anthem™ Blue Cross HMO	Anthem™ Medicare Preferred PPO
Kaiser Plans	Kaiser Permanente HMO	Kaiser Senior Advantage HMO	Kaiser Permanente HMO	Kaiser Senior Advantage HMO

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

Who can be enrolled?			
Coverage Level	You	Your eligible children	Your Spouse or Domestic Partner
Single Coverage	✓	✓	
Family Coverage*	✓	✓	✓

** If you enroll your eligible spouse or domestic partner, you must pay the necessary additional premiums, if any, for their coverage.*

Annual Open Enrollment

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

- Enroll in a Fund medical plan option if you are eligible
- Change from your current medical plan to a different one that is available in your area.
- Enroll in a dental plan option if you are eligible
- Change your dental plan choice
- Disenroll from a dental plan option if you are enrolled
- Review and update, if necessary, the family members you have enrolled in the Plan.

During Open Enrollment you may also disenroll from the Fund's medical coverage for the following calendar year. (See "If You Decline Retiree Health Care Plan Coverage" on page 8, and "Circumstances That May Result in Loss of Your Medical Coverage or Benefits" on page 18.)

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

Medicare Enrollment

Medicare Part A and Part B Coverage

Whether you are enrolled in the Indemnity PPO Medical Plan or an HMO, you and your enrolled Medicare-eligible dependent(s), if any, must also enroll in both Medicare Part A and Part B as soon as you become eligible for Medicare. Generally, that means you or your enrolled dependent(s):

- are no longer working, and
- are individually at least age 65, or are younger than age 65 but have qualified for Social Security disability or have end-stage renal disease.

If you or your enrolled dependent(s) meet the Medicare eligibility requirements but are still working and have coverage under that employer's health insurance plan, you or your enrolled dependent(s) may be able to delay Medicare enrollment without incurring a penalty. Please contact the Fund Office (877-284-2320) to confirm your or your enrolled dependent's status, and Medicare (800-633-4227) for more information.

If you or any of your enrolled dependents are eligible for Medicare but do not enroll in both Medicare Part A and Part B, your out-of-pocket costs may be substantially higher. If you or your enrolled dependent(s) become eligible for Medicare **before age 65** for any reason, **you must notify the Fund Office as soon as possible**.

If you wish to enroll in the Kaiser Senior Advantage HMO or the Anthem™ Medicare Preferred PPO when you become eligible for Medicare, see page 16 for more information. Please contact the Fund Office at 877-284-2320, ext. 445, for the appropriate enrollment form and instructions.

The Fund treats all retirees and their dependents who become eligible for Medicare as if they are enrolled in both Part A and Part B of Medicare, regardless of whether they are actually enrolled.

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

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

  Example: Medicare would have paid approximately 80% of your claim if you were enrolled in Medicare Part A and Part B. Because you didn't enroll in Medicare, you would be responsible for the 80% that Medicare would have paid, plus your normal share of the expenses under the Indemnity PPO Plan. In other words, you would have to pay 100% of the claim.

- **HMO Participants:** You will be disenrolled from the HMO and the Fund will move your coverage to the Indemnity PPO Medical Plan. Only after enrolling in Medicare Part A and Part B can you re-enroll in a Medicare Advantage HMO or PPO. Your benefits under the Indemnity PPO Medical Plan will be calculated as though you and your eligible dependent(s) are enrolled in Medicare, so and you will have higher out-of-pocket costs (see the example above). If you have been enrolled in a non-Medicare HMO while you are eligible for Medicare, you also have to reimburse the Fund for the difference in cost between the higher non-Medicare HMO premium the Fund actually paid and the lower Medicare Advantage HMO or PPO premium the Fund should have paid during the period you were not enrolled but were eligible for Medicare.

Medicare Part D Coverage

The Fund's Prescription Drug benefits, whether through the Fund or Kaiser, provides creditable Medicare Part D prescription drug coverage. **If you enroll in another Medicare Part D Prescription Drug Plan you will lose the benefits provided through the Fund, as follows:**

- If you or a Dependent are enrolled in the Indemnity PPO Medical Plan, or the Anthem™ Medicare Preferred PPO, your prescription drug coverage through the Fund will be automatically terminated; your PPO medical coverage will stay the same.
- If you are enrolled in Kaiser Senior Advantage both your Kaiser medical and drug coverage will be terminated. Your medical coverage will be moved to the Indemnity PPO Medical Plan, but you will not have prescription drug coverage through the Fund.

Medicare Advantage HMO or PPO Enrollment and Disenrollment

To enroll in the Kaiser Senior Advantage HMO or the Anthem™ Medicare Preferred PPO, you must complete that HMO/PPO's enrollment form and the Fund's enrollment form. If you wish to change from one Medicare Advantage plan (HMO or PPO) to another, fill out the Fund's Enrollment for Retirees form and the Kaiser or Anthem™ enrollment form. Send both forms to the Fund Office.

If you wish to disenroll from a Medicare Advantage plan (HMO or PPO), you must complete the HMO's disenrollment form as well as the *Enrollment for Retirees* form. Send both forms to the Fund Office.

Call the Fund Office if you need a Kaiser or Anthem™ enrollment form or disenrollment form.

When You Can Change Plans

If you are not yet eligible for Medicare, you can change plans:

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

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

If You Decline Retiree Health Care Plan Coverage

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

If you decline enrollment in retiree health coverage, you won't be able to re-enroll yourself or any of your eligible dependents until the third annual Open Enrollment following the date you declined coverage.

Declining Retiree Health Care plan coverage will result in a loss of the Fund's health care coverage for up to three years. Exceptions are made only if the Plan's special enrollment rights apply. See "Special Enrollment Rights" on page 9, and additional information on page 18.

If You Decline Retiree Dental Plan Coverage

If you decline retiree dental coverage when you retire, you must wait until the second annual Open Enrollment after your retirement date to enroll in the Retiree Dental Plan.

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

Eligible Dependents

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

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

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

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

Dependent Verification and Divorce Requirements

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

If the Fund has paid benefits and/or HMO/PPO premiums on behalf of your ineligible dependents (e.g., your divorced spouse or over age child), you will be required to reimburse the Fund for the full amount paid on their behalf. See page 18 for additional information.

Special Enrollment Rights

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

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

If you request a special enrollment within 120 calendar days of one of these events, coverage will be retroactive to the date the event occurred.

If you request a special enrollment more than 120 days following the event, but no later than the end of the next Open Enrollment period, your new coverage will begin on the first day of the month after the Fund Office receives your enrollment form.

If you have questions or need more information about Special Enrollment Rights, please contact the Fund Office at 877-284-2320, ext. 445.

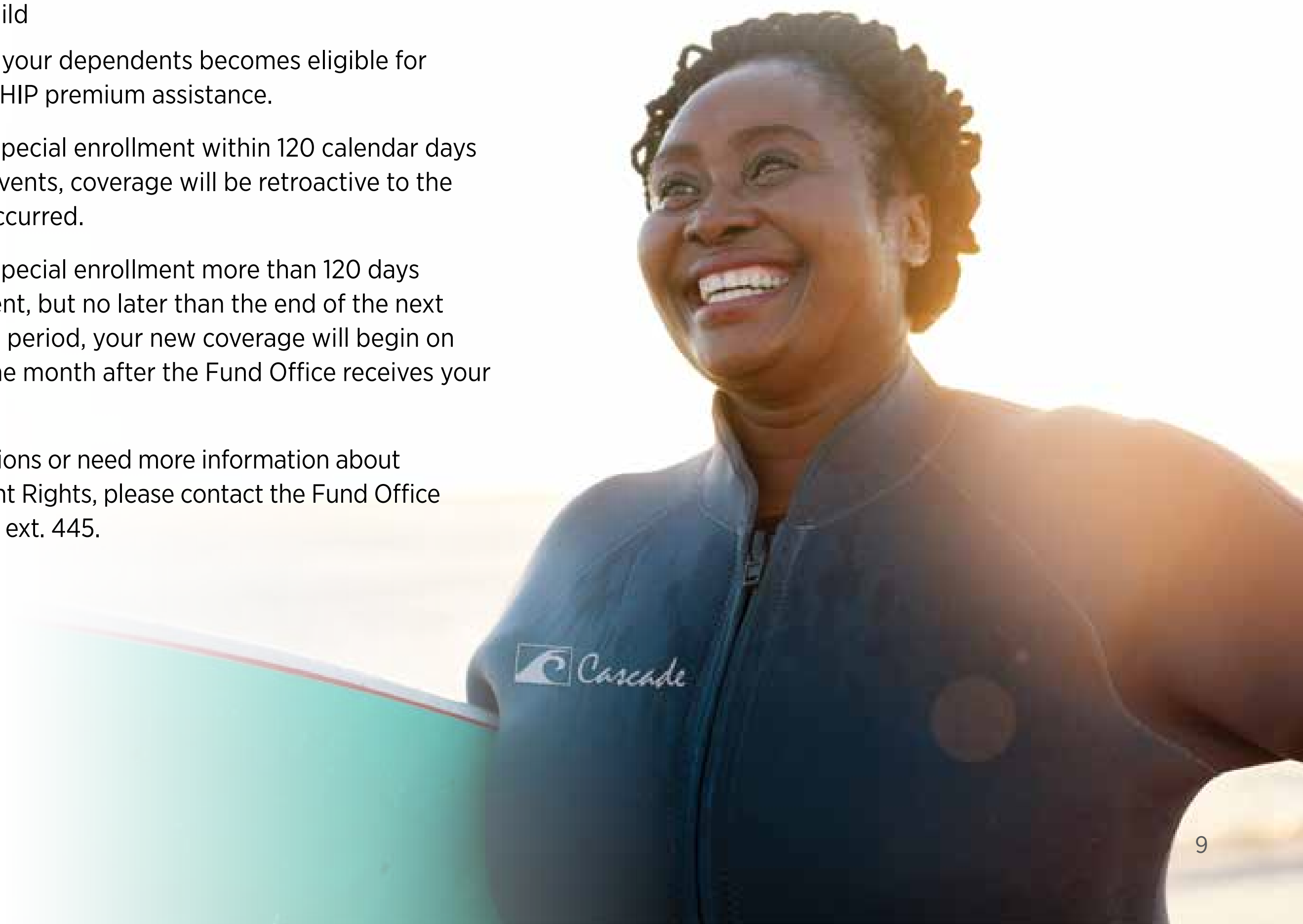
Your HIPAA Rights

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.

The Fund's *Notice of Privacy Practices* is available in the **"About the Fund"** section of the Fund's website at scufcwfunds.com. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

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

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



The Indemnity PPO Medical Plan

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

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

Important Indemnity PPO Medical Plan Terms

Allowed Amount: The maximum amount on which payment is based for covered health care services. In certain instances, the Allowed Amount is also called a Covered Charge or Covered Expense. If your provider charges more than the Allowed Amount, you may have to pay the difference.

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

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

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

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

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

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

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

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

Summary: How The Indemnity PPO Medical Plan Works—Non-Medicare*

When You Receive Care from PPO Providers	When You Are Not Eligible for Out-of-Area Benefits and You Receive Care from Non-PPO Providers
• The Plan covers many services, including doctors' visits, with no Annual Deductible after you pay a Copay. • For most services, such as inpatient hospital care, you have to satisfy the Plan's Annual Deductible of $500 per person/$1,500 per family before the Plan pays its share of your Covered Expenses. • Once you satisfy the Annual Deductible, you and the Plan share in the cost for most services through Coinsurance (25% is your responsibility; 75% is payable by the Plan). • For services from a PPO provider, you and the Plan pay a percentage of the "network contract rate" for a given service. PPO providers agree to keep their charges at or under the contracted rate. Note: the Plan limits benefits for certain medical services/supplies (e.g., Hip & Knee Replacement surgeries. See page 13 for additional information). • The Plan keeps track of the amount you pay in Coinsurance for PPO services. Once you reach the in-network $5,000 per person/$10,000 per family Annual Out-of-Pocket Maximum, the Plan pays 100% of your covered PPO charges for the rest of the calendar year, up to the Plan's lifetime maximum benefit limits.	• You first have to satisfy the Plan's non-PPO out-of-network Annual Deductible of $750 per person/$2,250 per family before the Plan starts paying any of your medical claims. • Once you satisfy the Annual Deductible, you and the Plan share the the cost of most services through Coinsurance (50% is your responsibility; 50% is payable by the Plan). • Often a non-PPO provider's charges are higher than the Allowed Amount. In addition to your Coinsurance, you are responsible for paying amounts that exceed the Plan's Allowed Amount. • There is no Out-Of-Pocket Maximum for services from non-PPO Providers, and the Plan will never pay 100% of the Covered Charge.

** Benefits may differ for retirees and dependents who are eligible for Medicare. The Plan limits benefits for certain medical services/supplies.*

Important Indemnity PPO Medical Plan Rules (for Non-Medicare Participants)

In-network, the Plan pays 75% of the Allowed Amount, versus 50% of the Allowed Amount for out-of-network, non-PPO care. In addition, PPO doctors, hospitals and other medical providers have agreed to charge the Fund's non-Medicare retirees and covered dependents lower, "preferred customer" contract rates. You save money when you receive care from PPO providers. Non-PPO providers can charge more than the Allowed Amount, and you are responsible for paying the difference.

All services received from non-PPO providers except Emergency Services, are subject to a higher Annual Deductible and a 50% Coinsurance. In addition, when you use non-PPO Providers, you are responsible for any charges that exceed the Allowed Amount.

Pre-certification for non-emergency hospital and other inpatient facility admissions is required for all individuals who are not covered by Medicare. Precertification is automatically performed if services are received through a PPO Provider in the Anthem™ Blue Cross Prudent Buyer network or the BlueCard PPO network for medical care; and HMC HealthWorks® (HMC) for mental/behavioral health and substance abuse care. Pre-certification is NOT automatic outside the PPO networks. Always make sure you obtain pre-certification before being admitted to a hospital or other inpatient facility.

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

The Plan limits benefits for certain medical services and supplies. Refer to your current *Retiree (Except E) Benefits Chart* for more information.

Women's Health and Cancer Rights

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

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

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

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

Outpatient Surgical Center Benefit Example (Non-Medicare)

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

Remember, the Plan limits benefits for certain medical services and supplies. Refer to your current *Retiree (Except E) Benefits Chart* and page 11 for more information.

Chiropractic and acupuncture benefits are provided only for those services listed in the Plan's schedule of allowances. There is a per-calendar-year combined benefit maximum for these services, which includes related x-ray and lab expenses. (See page 21 for more information about chiropractic care and acupuncture benefits.)

Employee Member Assistance Program (EMAP) benefits for mental/behavioral health and substance abuse treatment are subject to the same Annual Deductibles, Copays, 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 19 for more about EMAP benefits.)

Services for mental/ behavioral health care or treatment for substance abuse that are provided outside the EMAP and the HMC network are not covered. You will be responsible for all charges, except for Emergency Services.

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).

Non-Medicare Knee/Hip Replacement Hospital Benefit

The Fund, working with Anthem™ Blue Cross Prudent Buyer PPO 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 $35,000. 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 $35,000. Hospital charges for these surgeries typically include the cost for the hospital stay and the devices and materials needed for the replacement. The $35,000 Allowed Amount does not apply to charges from surgeons or other providers involved in your care. Separate calendar-year maximums apply for physician fees. Refer to your current R*etiree (Except E) Benefits Chart* for details.

Designated Hospitals

To keep hospital costs for knee and hip joint replacement within the $35,000 Allowed Amount, you have access to many well-known hospitals in California. These are called Designated Hospitals.

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

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

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

How the Knee/Hip Replacement Hospital Benefit Works

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

If you have your knee or hip replacement surgery at a Non-Designated Hospital: Your out-of-pocket costs could be extremely high. After you pay your Annual Deductible and your share of Coinsurance, you must also pay any charges above the $35,000 Allowed Amount. The Plan's Annual Out-of-Pocket Maximum will not limit your share of the costs.

However, if you use a Non-Designated Hospital that is in the Anthem™ PPO Network and the total charges are under the $35,000 Allowed Amount, you will not be penalized. Your out-of-pocket expenses will count toward your Annual Out-of-Pocket Maximum, just as if you had used a Designated Hospital.

If you do not live near a Designated Hospital: If you qualify for Out-of-Area Benefits, hospital charges will be covered as they are now for any other hospitalization, and the $35,000 Allowed Amount will not apply.

Non-Medicare Knee/Hip Replacement Cost Comparison

	Anthem™ Blue Cross Designated Hospital	Anthem™ Blue Cross Non-Designated PPO Hospital	Out-of-Network Non-PPO Hospital
Hospital Charges:	$30,000	$40,000	$45,000
Allowed Amount:	$35,000	$35,000	$35,000
Part One: You pay your share of the Allowed Amount (Annual Deductible and Coinsurance)			
	$5,500 You pay your $500 Annual Deductible plus 25% Coinsurance until you reach your Annual Out-of-Pocket Maximum of $5,000	**$9,125** You pay your $500 Annual Deductible plus 25% Coinsurance on remaining Allowed Amount ($34,500 x 25% = $8,625)	**$17,875** You pay your $750 Annual Deductible plus 50% Coinsurance on remaining Allowed Amount ($34,250 x 50% = $17,125)
Part Two: The Plan pays the remaining share toward the Allowed Amount			
	$24,500	$25,875	$17,125
Part Three: You pay all additional charges over the Allowed Amount			
	$0	$5,000	$10,000
Your Out-of-Pocket Cost:	**$5,500**	**$14,125**	**$27,875**

Benefits for Medicare-Eligible Retirees and Dependents

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

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

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

How to File a Medical Claim

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

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

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

  United Food & Commercial Workers Unions
  and Food Employers Benefit Fund
  PO Box 6010
  Cypress, California 90630-0010

- Mail additional bills or statements for any services covered by the Plan to the Fund Office as soon as you receive them.

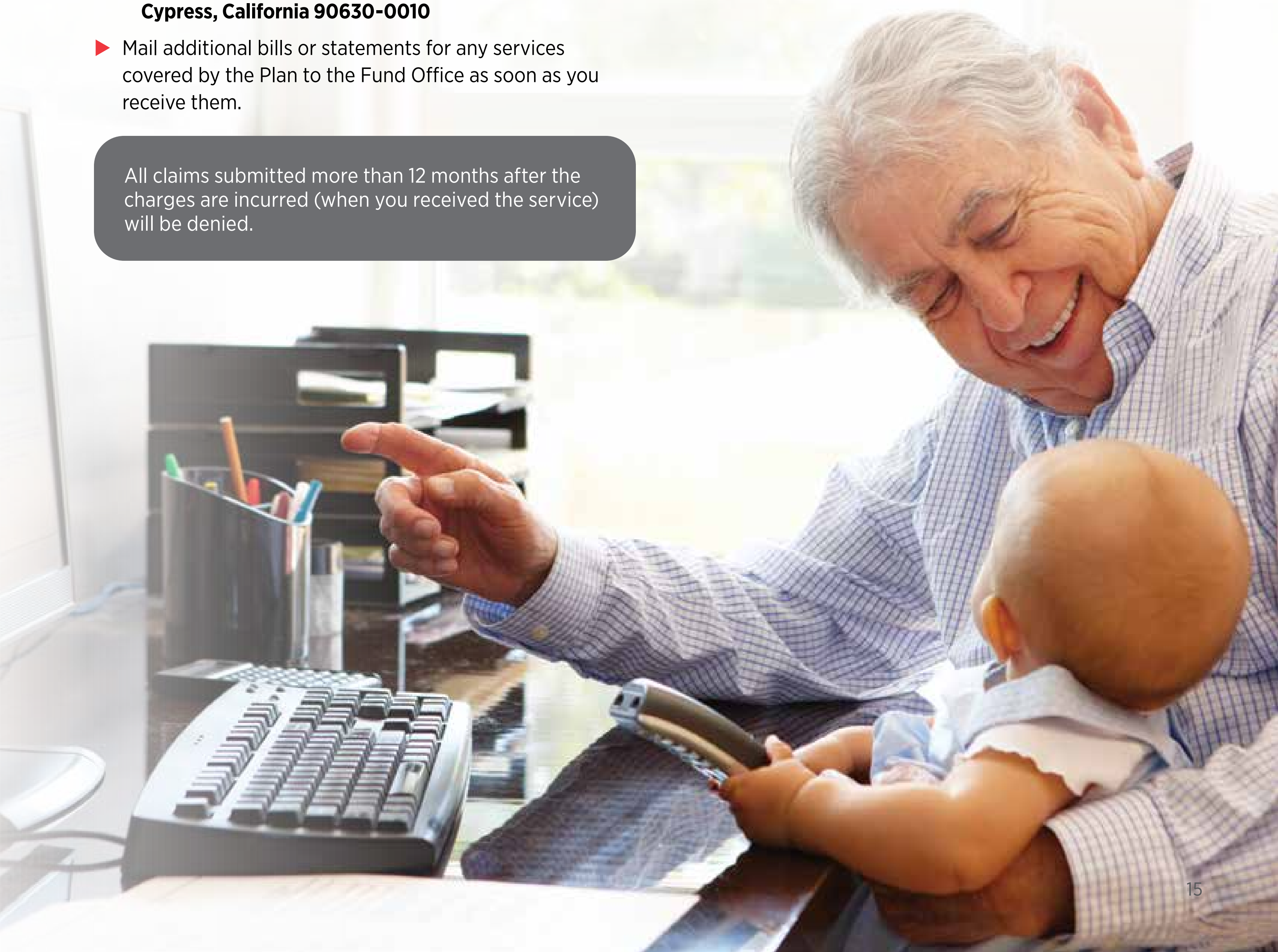
> All claims submitted more than 12 months after the charges are incurred (when you received the service) will be denied.

Assignment of Benefits

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

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

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



HMO Plans-Non-Medicare and Medicare Advantage

To enroll in one of the Fund-sponsored HMOs (Anthem™ Blue Cross HMO, the Kaiser Permanente HMO, or the Kaiser Senior Advantage HMO), you must live in its service area and you are restricted to using only that HMO's doctors and hospitals. If you use a doctor or hospital not affiliated with your HMO, your charges will not be reimbursed. Exceptions are made only for Emergency Services.

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

If you or an enrolled dependent are eligible for Medicare and choose Kaiser Senior Advantage HMO coverage, you must also be enrolled in Medicare Part A and Part B.

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

HMO Plan Options

If you choose HMO coverage, your covered dependents will be enrolled in the plan that corresponds to the one that you've selected, based on their eligibility for Medicare. For example, if you choose Kaiser and you are on Medicare, you will be enrolled in Kaiser's Senior Advantage HMO and your non-Medicare dependents (if any) will be enrolled in the traditional Kaiser Permanente non-Medicare HMO.

HMO Primary Care Physician (PCP) Requirements

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

Kaiser Permanente: Whether you are in the Kaiser HMO (for non-Medicare participants) or the Kaiser Senior Advantage HMO (for Medicare participants) you are encouraged but not required to to choose a PCP. In any event, participants must receive all of their health care from Kaiser providers and facilities (with the potential exception of needed Emergency Services).

Anthem™ Blue Cross HMO: This Plan requires that you choose a PCP. You must be enrolled in one of the two networks: the Anthem™ Select Network or the Anthem™ CA Care Network. Your eligible dependents must be enrolled in the same network, and may select their own PCP from within that network. Until you select a PCP, Anthem™ will assign one to you.

More detailed information about HMO benefits is included separately in the *Retiree (Except E) Benefits Chart* and each HMO's brochure.

Medicare Advantage PPO Plan

The Anthem™ Medicare Preferred PPO is a Medicare Advantage plan for Medicare eligible retirees and dependents. The plan allows you to see any provider who accepts Medicare, and referrals are not needed for specialists.

Your copay and coinsurance will be the same whether you use an in-network or out-of-network provider if your provider accepts Medicare. If you use a provider who does not accept Medicare, you may have significantly higher out-of-pocket costs. The best way to minimize your out-of-pocket cost is to use a provider who accepts Medicare. Please contact Anthem for more information.

Once you enroll in this plan you will receive a Medicare Advantage Enrollment Guide from Anthem. Refer to the Benefits Chart in this Enrollment Guide or the current *Retiree (Except E) Benefits Chart* for more information about member copays and coinsurance under this plan. Prescription drug coverage for this plan is provided by the Fund's Prescription Drug Program.

> Those enrolled in Kaiser Senior Advantage receive their prescription drug benefits through Kaiser. The Fund's Prescription Drug Program covers retirees and dependents enrolled in the Anthem™ Blue Cross HMO, the Anthem™ Medicare Preferred PPO and the Kaiser Permanente non-Medicare HMO. The Fund's Prescription Drug Program is explained beginning on page 19 of this booklet and in your current *Retiree (Except E) Benefits Chart*.

Coordination of Benefits Under the Indemnity PPO Medical Plan

If you have coverage under two or more plans, one is the primary plan while the others are secondary plans. The primary plan pays benefits first without regard to the other plans involved.

The Fund's Plan uses a "non-duplication of benefits" rule when the Plan pays secondary. The combined amount of benefits payable by this Plan and other plans, including Medicare, will not exceed the benefit that would have been paid had this Plan been the primary payer.

In addition, benefits paid by the Plan will not exceed the amount that would have been paid had no other plan been involved (this is referred to as the "normal benefit").

Non-Medicare Plans

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

- If the primary plan's payment is less than the normal benefits under this Plan, this Plan will pay the difference between its normal benefit and the amount paid by the primary plan.
- If the primary plan's payment is the same or greater than the normal benefits under this Plan, this Plan will not pay any benefits. This means you may still have some out-of-pocket expense even though two plans are involved.
- Any medical plan that has no coordination of benefits rule is automatically primary.

Medicare Plans

For retirees and dependents eligible for Medicare, Medicare coverage is the primary plan and pays first. Because Medicare is the primary payor, this Plan's benefits will be determined as follows:

- If Medicare's payment is less than the normal benefits under this Plan, this Plan will pay the difference between its normal benefit and the amount paid by Medicare.
- If Medicare's payment is the same or greater than the normal benefits under this Plan, this Plan will not pay any additional benefits.

For example, if this Plan would have reimbursed 75% for a given service, but Medicare already paid 80%, this Plan will make no additional payments.

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

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

Your medical coverage may be affected by the following circumstances.

- Enrollment:
  - No benefits are payable for treatment that you or a covered dependent receive before coverage begins or after coverage ends.
  - If you do not elect retiree medical coverage when you first retire, or if you lose your coverage in the future (e.g., disenrollment or failure to make your payments), you may not enroll in the Plan until the third annual Open Enrollment following the date you declined or lost your coverage (see page 8).
  - A new dependent must generally be enrolled within 120 days following the date of marriage, establishment of a domestic partnership, birth, adoption, or placement for adoption. No medical benefits are payable on behalf of a dependent who is not properly enrolled under the Plan (see pages 8 and 9).
  - You must notify the Fund if a covered dependent is no longer eligible for coverage (in the event of a divorce, for example). Otherwise you will be required to reimburse the Fund for amounts paid on the individual's behalf after he or she became ineligible (see page 9).
- The Fund's Indemnity PPO Medical Plan:
  - To receive the highest benefit under the Indemnity PPO Medical Plan, you must use in-network providers—you will have higher out-of-pocket costs if you use a non-preferred provider (see page 11).
  - If you use non-PPO (out-of-network) providers under the Indemnity PPO Medical Plan, you must file a claim before benefits can be paid (see page 15).
  - There is a 20% reduction in benefits for not complying with precertification requirements for non-emergency hospital and other inpatient facility admissions. Precertification is automatically performed by in-network providers, but not by non-preferred providers (see page 11).
  - The Plan limits benefits for certain medical services and supplies. Refer to your current *Retiree (Except E) Benefits Chart* for details.
- HMO Plans:
  - If you are enrolled in an HMO and receive non-emergency services from a provider that is not affiliated with your HMO, your charges will not be reimbursed (see page 16).
  - If you move outside the HMO's service area, you are not eligible for coverage by that HMO (see page 16).
  - HMOs may limit benefits for certain medical services and supplies. Refer to your current *Retiree (Except E) Benefits Chart* for details, or request an *Evidence of Coverage* from your HMO.
- All Plans:
  - If you or a covered family member are eligible for Medicare but do not enroll in Medicare Part A **and** Part B, you will have substantially higher out-of-pocket costs (see page 7).
  - If your monthly payment for health care is not postmarked or delivered to the Fund Office by the Due Date, your coverage will be terminated on the Due Date. Your coverage will be reinstated if you make payment within the 30-day grace period immediately following the Due Date (see page 5).
  - If you recover money in connection with injuries caused by a third party (for example, as the result of a lawsuit, automobile accident, etc.), the Plan is entitled to recoup the money it paid on your behalf related to such injuries. You are required to assist the Plan in recovering this money.
  - The Plan has the right to recover amounts that are paid to you or on your behalf by mistake. For example, if a claim payment exceeds the amount allowed by the Plan, the Plan has the right to recover the excess amount from you or the provider that received it (see page 7.

Employee Member Assistance Program (EMAP)

The EMAP helps those who are enrolled in the Indemnity PPO Medical Plan or the Anthem™ Blue Cross HMO with problems that can adversely affect mental health and wellbeing. Those enrolled in the Kaiser non-Medicare HMO, Kaiser Senior Advantage HMO or the Anthem™ Medicare Preferred PPO receive similar services through those plans.

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

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

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

Prescription Drug Program

The Fund provides prescription drug benefits through the Prescription Drug Program for all of its medical plan options except Kaiser Senior Advantage. Kaiser Senior Advantage members must obtain their prescription drugs from Kaiser pharmacies.* The Fund's prescription drug benefits are administered by Caremark, using the Standard Control Formulary.

Participating Pharmacies

Except as noted above for Kaiser Senior Advantage members, you must use a UFCW Unions and Food Employers Participating Pharmacy or Mail Service Pharmacy to receive prescription drug benefits. Participating pharmacies are available across the United States. Register and login to **caremark.com** to find participating pharmacies. You may also download the Caremark/CVS Caremark app, or call 855-311-3162.

Prescriptions filled at non-participating pharmacies, including HMO pharmacies, are not covered except in the event of an emergency or in certain situations where a Participating Pharmacy is not available.

The Fund's Prescription benefits provide creditable Medicare Part D prescription drug coverage. See "Medicare Part D Coverage" on page 7.

Prescription Drug Copays

You don't have to satisfy a deductible to receive prescription drug benefits. You pay your portion of the cost of a covered prescription drug by making a copay (copayment). For current copay amounts, refer to the current *Retiree (Except E) Benefits Chart* available on the Fund's website at **scufcwfunds.com**.

Copays vary depending on whether the prescription is:

- A generic drug or a brand name drug
- A formulary or non-formulary drug
- A maintenance medication included in one of the Fund's special therapeutic classes of drugs 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.

Your copays are lower for formulary generic and formulary brand-name drugs.

* Please refer to your *Retiree (Except E) Benefits Chart* for details on the prescription drug benefits under Kaiser Senior Advantage.

What is a formulary?

A formulary is a list of generic and brand-name drugs selected by a panel of expert pharmacists and physicians. The panel of experts selects drugs to be on the formulary that are both clinically and cost effective.

Drugs on the formulary are preferred drugs and are "formulary generic" or "formulary brand-name" drugs. Drugs not on the formulary are non-preferred or "non-formulary", or "formulary excluded."

To help you and your doctor identify lower cost prescription drugs for treating many common health conditions, tell your doctor to refer only to the Caremark formulary when writing your prescriptions.

Some medications may not be covered unless Caremark pre-authorizes the prescription. Some medications may require a different copay. Caremark will contact you if your prescribed medication falls into this category. You may be required to work with your doctor to determine the appropriate action, such as whether switching to another drug is an option or if your doctor should try to obtain prior authorization on your behalf.

When you use formulary generic or formulary brand-name drugs to treat a condition, you will pay the applicable generic or brand copay. However, if you use a drug that is not on the formulary, your out-of-pocket cost will be much higher. For brand name drugs that have a generic equivalent, unless your doctor indicates "dispense as written", you will pay the applicable generic copay PLUS the price difference between the brand name drug and generic drug.

Note the following program rules to maximize cost-effectiveness and drug safety:

- Medications that lack FDA approval for safety and effectiveness, have a clinically appropriate alternative or are compound medications may be excluded or require prior authorization by Caremark.
- Caremark will ensure that you are using medications that are the most effective and priced right. You may be asked to try a lower-cost generic medication first, even if your doctor prescribes a brand-name drug. If the generic medication does not work effectively, the Plan will cover the prescribed brand-name drug.
- Opioid medications will have a coverage limit, or you may be encouraged to use short-acting opioids before using long-acting opioids.
- Specialty medications (e.g., for a condition like rheumatoid arthritis or multiple sclerosis), require prior authorization. CVS Specialty® Pharmacy will work with your doctor to review your medication and treatment plan to ensure the safe, clinically appropriate, and cost-effective use of these medications. You may have your specialty medication delivered directly to your home through the CVS Specialty® Pharmacy.

HMO/PPO Coverage for Self-injectable Medications

The HMOs and the Anthem™ Medicare Preferred PPO may not cover all self-injectable medications. Therefore, the Fund provides the following coverage for prescribed self-injectable medications other than insulin:

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

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

Vision Care Benefits

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

At the end of the calendar year, any unused vision benefits, up to one-half of the annual maximum, will be carried over to the next calendar year. The maximum unused amount that can be carried over in any calendar year is $62.50. Unused vision benefits can only be used for vision services covered by the Fund.

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

Acupuncture and Chiropractic Benefits

Acupuncture and chiropractic care benefits are provided for retirees and dependents enrolled in all of the Fund's medical plans.

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

Treatments by an acupuncturist or a chiropractor have the same Copay as any other doctor's visit, which is $25.00. The Plan will reimburse 100% of the Allowed Amount for covered procedures minus the Copay.

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

For HMO and Anthem™ Medicare Preferred PPO Plan Participants, related diagnostic testing is reimbursed at 75% of the Allowed Amount for covered procedures.

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

Podiatry Benefits

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

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

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

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

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

Dental Plan Options

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

The Fund offers a choice between the Indemnity Dental Plan and the Prepaid Dental Plan.

Both plans cover dental services so long as the service qualifies as a "Covered Procedure." Covered Procedures include preventive and diagnostic services and basic and major restorative services. No benefits are provided for services that do not meet the Fund's definition for "Covered Procedure." See your *Dental Program for All Participants in All Plans and All Retirees* booklet for a description of Covered Procedures.

Enrollment

See page 6 for details about enrolling for retiree dental coverage. Remember, if you elect dental coverage for yourself, your eligible dependents are also covered for dental benefits at no additional charge, even if they are not enrolled in your medical plan.

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

Once you disenroll from the Dental plan, you must wait until the third annual Open Enrollment after rejecting dental coverage to enroll again unless you disenrolled from both the Medical and Dental plans and your reenrollment is approved in accordance with the Plan's "Special Enrollment Rights" provisions outlined on page 9. Contact the Fund Office if you have questions.

Cost of Coverage

If you elect dental coverage, you must pay monthly and enroll for a full year's coverage. During annual Open Enrollment the Fund will announce the monthly cost for dental coverage effective January 1 of the following calendar year.

Indemnity Dental Plan

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

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

At the end of the calendar year, any unused dental benefits, up to one-half of the annual maximum, will be carried over to the next calendar year. The maximum amount that can be carried over in any calendar year is $900. Unused dental benefits can only be used for services covered by the Fund's Indemnity Dental Plan. Claims will be paid in the order that they are processed. Payment of claims will be made based on the benefit amount available at the time the claims are processed.

Prepaid Dental Plans

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

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

For a comparison of the Indemnity Dental Plan benefits to those of the Prepaid Dental plan, please refer to your *Retiree (Except E) Benefits Chart* and the *Dental Program for Active Participants in All Plans and All Retirees* booklet.

Death Benefits

If you are an Eligible Retiree at the time of your death, a benefit of $1,000 to $5,000 (depending on your retirement date) will be paid to your beneficiary.

An Eligible Retiree is one who qualifies for and is enrolled in the Retiree Health Plan, including an Eligible Retiree enrolled as a dependent under another Eligible Retiree's coverage, and who has made timely payment of all premiums required for coverage.

A Death Benefit may also be payable if you qualify for Retiree Health and Welfare Benefits at retirement, but die before becoming eligible for the benefit at age 55.

A claim for death benefits must be postmarked or received at the Fund Office within one year of death.

No benefit is payable upon the death of a spouse, domestic partner or child.

Naming a Beneficiary

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

If no beneficiary is named or surviving upon your death, the Death Benefit will be paid to the first individual(s) listed below who is living at the time of your death:

1. Your spouse, if none then
2. Your children, share and share alike; if none then
3. Your parents, including adoptive parents, share and share alike; if none then
4. Your siblings, share and share alike.

If there are no such individuals living at the time of your death then, in lieu of a death benefit, the Plan will pay the person who presents evidence of payment of burial expenses an amount not to exceed $1,000 for the burial expenses.

How to File a Claim for Death Benefits

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

COBRA Continuation Coverage

The Fund offers COBRA coverage to a retiree's covered spouse or covered child who has a Qualifying Event that causes a loss of coverage. Each qualified beneficiary will have an independent right to elect COBRA coverage.

Qualifying Events for the retiree's spouse include loss of coverage as a result of (a) the retiree's death; or (b) divorce from the retiree. Qualifying Events for a retiree's dependent children include loss of coverage as a result of (a) the retiree's death; (b) the retiree's divorce (e.g., if the child is the retiree's stepchild); or (c) the dependent child ceasing to meet the definition of a "dependent" as defined by the Plan.

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

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

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

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

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

Once an election for either Core Benefits Only or Core-Plus Benefits is made, the election may not be changed.

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

COBRA participants can buy only the plan of benefits that he or she had prior to the Qualifying Event that made him or her eligible for COBRA coverage, with certain exceptions. For example, HMO participants may switch to the Indemnity PPO Medical Plan if they are moving outside the HMO's Service Area or during the Fund's annual Open Enrollment period.

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

Benefit Plan Contacts

Organization	Phone Number	Address	Website
Southern California United Food & Commercial Workers Unions and Food Employers Joint Benefit Funds Administration, LLC	877-284-2320 (see extensions below)	6425 Katella Avenue Cypress, CA 90630-5238 PO Box 6010 Cypress, CA 90630-0010	**scufcwfunds.com**
COBRA	Extension 441		
Death Benefits	Extension 447		
Dental	Extension 428		
Eligibility	Extension 422		
Enrollment	Extension 420		
Medical	Extension 424		
Retiree Enrollment	Extension 445		
Pension	Extension 434		
Prescription	Extension 432		
Participating Union Locals			
UFCW Local 8 — Bakersfield	661-391-5773 or 661-391-5770	1910 Mineral Ct. Bakersfield, CA 93308	**ufcw8.org**
UFCW Local 135			**ufcw135.com**
San Diego (Main Office)	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			**ufcw324.org**
Buena Park	714-995-4601 or 800-244-8329	8530 Stanton Avenue Buena Park, CA 90620	
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 92351	

Organization	Phone Number	Address	Website
Participating Union Locals			
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 Blvd., 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 Prudent Buyer PPO		**anthem.com/ca/**
Hospital review/preauthorization	800-274-7767	
Find a PPO provider — California	855-686-5613	
Find a PPO provider — Outside California	800-810-2583	
Kaiser Permanente HMO (non-Medicare)	800-464-4000	**kp.org**
Kaiser Senior Advantage HMO	800-443-0815	**kp.org/medicare**
Anthem™ Blue Cross HMO (non-Medicare)	800-227-3771	**anthem.com/ca/**
Anthem™ Medicare Preferred PPO	833-848-8730	**anthem.com/ca/**
Caremark – Prescription Drugs	855-311-3162	**caremark.com**
HMC Employee Member Assistance Program (EMAP)	800-461-9179	**hmchealthworks.com**
Podiatry Plan, Inc.	800-367-7762 or 415-928-7762	**podiatryplan.com**

Notes

Notes

Your benefits information is available through your mobile phone and online! Scan this code to go to the portal now.

scufcwfunds.com/portal