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**United Food & Commercial Workers Unions and Food Employers Benefit Fund**

6425 Katella Avenue, Cypress, CA 90630-5238 P.O. Box 6010, Cypress, California 90630-0010

# Retiree (Except E) Benefits Chart for Calendar Year 2022

**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[1] | | | |
|---|---|---|---|
| **PLAN FEATURES & BENEFITS** | **IN-NETWORK (PPO)** | **OUT-OF-AREA[2]** | **OUT-OF-NETWORK (NON-PPO)** |
| **Lifetime Maximum Benefit** | $1.5 million reduced by the lesser of: (1) the lifetime benefits paid under the active Participant's[3] Indemnity PPO Medical Plan or (2) $500,000. Registered nurse services are limited to $525,000 per person. Does not include benefits paid for prescription drug, vision, or dental services. | | |
| **Annual Deductible** | $500 per person / $1,500 per family | | $750 per person / $2,250 per family |
| **Annual Out-of-Pocket Maximum** | $5,000 per person / $10,000 per family for covered charges subject to coinsurance; ***excludes*** deductibles, dental expenses, vision care expenses, prescription drug expenses, and expenses in excess of benefit maximums | | None |
| **Covered Charges[1]** | Allowed Amount for the applicable network: Blue Cross Prudent Buyer PPO, BlueCard (outside of California), HMC, or Podiatry Plan, Inc. | The Plan's Allowed Amounts as determined by the Fund. The Retiree is responsible for charges that exceed Allowed Amounts. | |
| **Plan Coinsurance** | After deductible, Plan pays 75% of Allowed Amount | | After deductible, Plan pays 50% of Allowed Amount |
| **Additional Accident Benefit** | $300 for covered services rendered within 90 days of the accident | | |
| **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). Outpatient surgery. Alternative birthing center. | | |
| • Precertification Requirement | Automatically processed by PPO provider | 20% benefit reduction for non-compliance | |
| • Knee/Hip Joint Replacement Surgery | **Designated Hospital or out-of-area hospital**: After deductible, Plan pays 75% of covered charges. **Non-designated PPO hospital**: After deductible, Plan pays 75% of the Allowed Amount, which is limited to $35,000 per confinement. The patient is responsible for charges over the Allowed Amount. | | After deductible, Plan pays 50% of covered charges based on an Allowed Amount of $35,000 per confinement. |

[1] 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. This plan is not a Medicare Supplemental Plan.

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

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

## Retiree (Except E) Benefits Chart for Calendar Year 2022

| INDEMNITY PPO MEDICAL PLAN (Continued) | | | |
|---|---|---|---|
| **PLAN FEATURES & BENEFITS** | **IN-NETWORK (PPO)** | **OUT-OF-AREA** | **OUT-OF-NETWORK (NON-PPO)** |
| **Emergency Room** | No deductible, Plan pays 100% of covered charges after $75 copay for treatment within 24 hours after emergency occurs (copay is waived if patient is admitted to hospital) | | |
| **Urgent Care Facility** | No deductible, Plan pays 100% of covered charges after $75 copay | | |
| **Ambulance** | After deductible, Plan pays 75% of Allowed Amount | | |
| **Professional Services** | After deductible, Plan pays 75% of Allowed Amount | | After deductible, Plan pays 50% of Allowed Amount[1] |
| • Partial List of Covered Services | Surgeon. Anesthetist/anesthesiologist. Injections & immunization. Administration of chemotherapy & radiation drugs. Physical therapy (subject to office and home visit maximums). Inhalation therapy. Cardiac rehabilitation. Home health care. Case management. Hemodialysis. Mastectomy & breast reconstruction. | | |
| • Limitations | Surgeon (includes TMJ surgery) – $3,000 maximum per calendar year. Assistant surgeon – $700 maximum per calendar year. Physical therapy – subject to office and home visits maximum. Speech therapy – $525 maximum per calendar year. Orthoptics – $125 maximum per calendar year. Podiatric surgery must be authorized by Podiatry Plan, Inc. and performed by a Podiatry Plan, Inc. provider. | | |
| **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 by the Plan. The $10,000 maximum for donor search fees applies ONLY to donor search fees and not to expenses of the donor. | | |
| **Doctor's Visits/Services** | No deductible, Plan pays 100% of Allowed Amount up to Plan limitations (see below) after a $25 copay per visit | | After deductible, Plan pays 50% of Allowed Amount |
| • Covered Services | Physician office/home/hospital visits, including podiatry services (from a Podiatry Plan, Inc. provider). Well-baby care. PSA screening. | | |
| • Limitations | Annual physical exam: $80 maximum per person per calendar year. Pap smear exam: two per year. Office and home visits: $3,150 maximum per person per calendar year, including $1,050 maximum for specialist visits. | | |
| **Outpatient Surgical Centers** | After deductible, Plan pays 75% of Allowed Amount | After deductible, Plan pays 75% up to Allowed Amount | After deductible, Plan pays 50% of Allowed Amount up to a maximum of $1,000[2] |
| **Outpatient Diagnostic Services** | After deductible, Plan pays 75% of Allowed Amount | | After deductible, Plan pays 50% of Allowed Amount |
| • Covered Services | Outpatient x-ray/lab. Pre-admission testing (within 7 days of hospitalization). Pap smear. PSA screening. Acupuncture/chiropractic related x-ray/lab. | | |
| • Limitations | Outpatient x-ray/lab, including mammogram – $400 maximum per person per calendar year | | |
| **Chemotherapy/Radiation/ Antigen Infusion Drugs** | No deductible, Plan pays $10 per agent | | NOT COVERED |
| **Mobile Screening Units** | Paid as any other covered service | | |

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

[2] Any charges in excess of this maximum do not count toward the Plan's annual deductible or Annual 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 & Supplies** | After deductible, Plan pays 75% of Allowed Amount | | After deductible, Plan pays 50% of Allowed Amount |
| • Family Planning | All FDA-approved birth control drugs and devices, excluding oral contraceptives (which, if prescribed, are covered through the Prescription Drug Program). No benefit for other drug or device during the effective period when one type is already in use. | | |
| • Medical Supplies & Equipment | Injectable drugs (except insulin, which is covered through the Prescription Drug Program). Artificial limbs. Orthopedic appliances. Glucose home monitor. Mastectomy prosthesis. Orthopedic shoes. Colostomy supplies. Hearing aids. Health aids. | | |
| • Limitations | Mastectomy prosthesis: $315 maximum per calendar year. Orthopedic shoes: $315 maximum per calendar year. Orthotics: $210 maximum per calendar year. Hearing aids: $840 maximum for one or $1,050 for two during any three-year period. | | |
| **Acupuncture/Chiropractic** | Only those services listed in the Plan's Schedule of Allowances are covered. (Schedule is available online at scufcwfunds.com/healthcare/active-participants/chiropractic-careacupuncture/) | | |
| • Office visits | No deductible, Plan pays 100% of Allowed Amount up to Plan limitations after a $25 copay per visit | | |
| • X-ray | After deductible, Plan pays 75% of Allowed Amount up to Plan limitations | | |
| • Covered Services | Office visits, manipulations, modalities, x-rays, and referrals by a chiropractor | | |
| • Limitations | $500 combined maximum per person per calendar year, including related x-ray (benefits paid for x-ray are included in $400 annual maximum for Outpatient Diagnostic Services) | | |
| **Podiatry Services** | Services must be authorized by Podiatry Plan, Inc. and rendered by Podiatry Plan, Inc. participating providers | | |
| • Office Visits | No deductible, Plan pays 100% of Podiatry Plan, Inc. allowance after a $25 copay per visit | | **NOT COVERED.** If you need podiatry services, contact Podiatry Plan, Inc. at 800-367-7762 or 415-928-7762. |
| • X-ray | After deductible, Plan pays 75% of Podiatry Plan, Inc. allowance | | |
| • Covered Services | Physician office/home/hospital visits, surgeon, and x-ray | | |
| • Limitations | All individual maximums apply (benefits paid for x-ray are included in $400 annual maximum for Outpatient Diagnostic Services) | | |

| INDEMNITY PPO MEDICAL PLAN – EMPLOYEE MEMBER ASSISTANCE PROGRAM (EMAP) BENEFITS[1] For Mental/Behavioral Health and Substance Abuse | | | |
|---|---|---|---|
| **PLAN FEATURES & BENEFITS** | **IN-NETWORK (PPO)** | **OUT-OF-AREA** | **OUT-OF-NETWORK (NON-PPO)** |
| **Covered Services** | All non-emergency services must be authorized by HMC and rendered by HMC participating providers | | |
| Inpatient Mental/Behavioral Health | After deductible, Plan pays 75% of HMC contracted rates | | **NOT COVERED.** If you need EMAP services, contact HMC at 800-461-9179. |
| Limitations | Maximum 60 days of inpatient care per calendar year, up to 120 days per lifetime | | |
| Outpatient Mental/Behavioral Health | No deductible. Plan pays 100% of HMC contracted rates after a $25 copay for an individual session or a $12.50 copay for a group session | | |
| Limitations | Maximum 30 visits per person per calendar year, combined with outpatient substance abuse | | |
| Inpatient Substance Abuse | After deductible, Plan pays 75% of HMC contracted rates | | |
| Limitations | Three lifetime chemical dependency confinements per person; $25,000 lifetime maximum per person combined with outpatient substance abuse | | |
| Outpatient Substance Abuse | No deductible. Plan pays 100% of HMC contracted rates after a $25 copay for an individual session or a $12.50 copay for a group session | | |
| Limitations | Maximum 30 visits per person per calendar year, combined with outpatient mental/behavioral health; $25,000 lifetime maximum per person combined with inpatient substance abuse | | |

[1] EMAP benefits are subject to the Lifetime Maximum Benefit, annual maximum benefits, annual Deductible, and Annual-Out-of-Pocket Maximum.

## Retiree (Except E) Benefits Chart for Calendar Year 2022

| NON-MEDICARE - Health Maintenance Organizations (HMOs)[1] For Retirees and/or Dependents who are not eligible for Medicare | | | | |
|---|---|---|---|---|
| **PLAN FEATURES & BENEFITS** | **KAISER PERMANENTE HMO** | **ANTHEM™ BLUE CROSS HMO[2]** | | |
| **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 or the Anthem™ Blue Cross HMO (CACare) network, and each enrolled family member must choose 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 | | |
| **Covered Charges** | Only services received from HMO providers are covered except in emergency situations | | | |
| **Annual Deductible** | None | None | | |
| **Annual Out-of-Pocket Maximum** | $1,500 per person / $3,000 per family | $1,500 per person / $4,500 per family | | |
| | **Kaiser Providers** | **Anthem™ Select HMO Network** | **Anthem™ Blue Cross HMO (CACare) Network** | **Outside the Anthem™Select HMO Network Area[2]** |
| **Primary Care Physician (PCP) Office Visits** | $25 copay per visit | $25 copay per visit | $35 copay per visit | $25 copay per visit |
| **Specialist Office Visits** | $35 copay per visit | $35 copay per visit | $45 copay per visit | $35 copay per visit |
| **Urgent Care** | $25 copay per visit | $25 copay per visit | $50 copay per visit | $25 copay per visit |
| **Emergency Room Visits[3]** | $100 copay per visit | $100 copay per visit | $150 copay per visit | $100 copay per visit |
| **Outpatient Surgery** | $150 copay per procedure | $150 copay per procedure | $200 copay per procedure | $150 copay per procedure |
| **Hospital Services** | $500 copay per admission | $500 copay per admission | $750 copay per admission | $500 copay per admission |
| **Other Services and Supplies** | Family planning, preventive care, podiatry, medical equipment and supplies, and hearing aids are provided through the HMO. | | | |
| **Injectables (except insulin)** | As provided through the HMOs. If not covered by the HMO, paid by the Fund at 75% up to a maximum out-of-pocket of $2,500 per year. | | | |
| **Prescription Drugs** | Provided through the Fund's Prescription Drug Program. See "Prescription Drugs" on page 8 and "Injectables (except insulin)" directly above. | | | |
| **Acupuncture/Chiropractic** | Provided by the Fund. After a $25 copay, the Plan pays 100% of the scheduled allowance for each office visit and 75% of the scheduled allowance for x-ray/lab. Only those services listed in the Schedule of Allowances are covered. $500 annual maximum benefit per person combined for all services. | | | |
| **Mental/Behavioral Health Services** | **Provided through Kaiser** | **Provided through EMAP administered by HMC** | | |
| • Outpatient Visits | $25 copay per individual visit; $12 copay per group session | $25 copay per individual visit with counselor or Ph.D. (e.g., psychologist); $35 copay per individual visit with M.D. (e.g., psychiatrist); $12.50 copay for group sessions. Annual maximum of 30 visits per person. | | |
| • Inpatient Hospitalization | $500 copay per admission | After $500 copay per admission, Plan pays 100% of HMC contracted rates. Limited to 60 days per person per year and 120 days per person per lifetime. | | |
| **Substance Abuse Services** | **Provided through Kaiser** | **Provided through EMAP administered by HMC** | | |
| • Outpatient Visits | $25 copay per individual visit; $5 copay per group session | $25 copay per individual visit with counselor or Ph.D. (e.g. psychologist); $35 copay per individual visit with M.D. (e.g., psychiatrist); $12.50 copay for group sessions. Annual maximum of 30 visits per person. | | |
| • Inpatient Detox/Hospitalization | $500 copay per admission | Plan pays 100% of HMC contract rates after $500 copay per admission. Lifetime maximum is three acute substance abuse confinements. $25,000 lifetime maximum per person combined with outpatient substance abuse. | | |
| • Transitional Residential Recovery Services/Treatment Facility | $100 copay per admission | | | |

[1] Refer to each Health Maintenance Organization's *Evidence of Coverage* booklet for coverage details. To enroll in the Kaiser HMO or the Anthem™ Blue Cross HMO, ***you must live in its service area***.

[2] Anthem™ Select HMO Network copays apply to Participants who do not have access to Anthem™ Select HMO Network providers.

[3] Emergency room copay is waived if admitted, but inpatient hospital copay will apply.

## Retiree (Except E) Benefits Chart for Calendar Year 2022

| MEDICARE - Medicare Advantage Plans (including Kaiser) For Retirees who are eligible for Medicare | | | |
|---|---|---|---|
| **PLAN FEATURES & BENEFITS** | **KAISER SENIOR ADVANTAGE HMO** | **ANTHEM™ MEDICARE PREFERRED PPO** | |
| | | **In Network** | **Out-of-Network** |
| **Choice of Provider** | You must receive all care from Kaiser providers and facilities, except in emergency situations | You may go to doctors, specialists, and hospitals in or out of network who accept Medicare. You do not need a referral. **Some benefit categories include services that require pre-authorization. Please contact Anthem for more information** | |
| **Lifetime Maximum Benefit** | None | None | |
| **Covered Charges** | Only services received from Kaiser providers and facilities are covered except in emergency situations. | The plan will cover services from either in-network or out-of-network providers if the services are covered benefits and medically necessary. As long as the provider accepts Medicare, your copay and coinsurance will be the same whether you use in-network or out-of-network providers. 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. | |
| **Annual Deductible** | None | None | |
| **Annual Out-of-Pocket Maximum** | $1,500 per person / $3,000 per family | $6,700 per person, combined in-network and out-of-network | |
| **Primary Care Physician (PCP) Office Visits** | $25 copay per visit | $25 copay per visit | |
| **Specialist/Non-physician Office Visits** | $25 copay per visit | $25 copay per visit | |
| **Urgent Care** | $25 copay per visit | $25 copay per visit | |
| **Emergency Room Visits**[2] | $50 copay per visit | $50 copay per visit | |
| **Outpatient Surgery** | $25 copay per procedure | $0 copay per procedure (preauthorization required) | |
| **Hospital Services** | $500 copay per admission | $500 copay per admission (preauthorization required) | |
| **Routine Preventive Care**[3] | 100% covered | 100% covered | |
| **Other Services and Supplies** | Family planning, preventive care, podiatry, medical equipment and supplies, and hearing aids are provided.[1] | Preventive care, routine hearing services[4], routine vision services, podiatry, medical equipment & supplies, hearing aids, and SilverSneakers® Membership. | |
| **Injectables (except insulin)** | As provided through the HMO or PPO. If not covered by the HMO or PPO, paid by the Fund at 75% up to a maximum out-of-pocket of $2,500 per year. | | |
| **Prescription Drugs** | Drugs must be obtained at Kaiser pharmacies. $10 copay for generic and $25 copay for brand-name drugs. Only formulary drugs are covered. No additional Benefit Fund coverage, except injectables, as noted directly above | Provided through the Fund's Prescription Drug Program. See" Prescription Drugs" on page 6 and "Injectables (except insulin)" directly above | |
| **Acupuncture/Chiropractic** | Provided by the Fund. After a $25 copay, the Plan pays 100% of the scheduled allowance for each office visit and 75% of scheduled allowance for x-ray/lab. Only those services listed in the Schedule of Allowances are covered. $500 annual maximum benefit per person combined for all services. No benefit will be paid by the Fund for services covered by HMO.[5] | | |

[1] Refer to Kaiser's *Evidence of Coverage* booklet for coverage details. To enroll in the Kaiser Senior Advantage HMO, ***you must live in its service area*** and be enrolled in Medicare.
[2] Copay waived if admitted.
[3] Coverage based on Medicare preventive care guidelines. Well-baby and prenatal visit copays vary.
[4] You must use a Hearing Care Solutions participating provider. Refer to Anthem's Evidence of Coverage booklet for coverage details.
[5] HMOs may cover manual stimulation of the spine to the extent covered by Medicare.

## Retiree (Except E) Benefits Chart for Calendar Year 2022

| MEDICARE - Medicare Advantage Plans (including Kaiser) For Retirees who are eligible for Medicare (Continued) | | |
|---|---|---|
| **Mental/Behavioral Health Services** | **Provided through Kaiser** | **Provided through Anthem™ Medicare Preferred PPO** |
| • Outpatient Visits | $25 copay per visit | $25 copay per professional individual therapy visit<br>$25 copay per professional group therapy visit<br>$0 copay per outpatient hospital facility individual therapy visit<br>$0 copay per outpatient hospital facility group therapy visit |
| • Inpatient Hospitalization | $500 copay per admission | $500 copay per admission |
| **Substance Abuse Services** | **Provided through Kaiser** | **Provided through Anthem™ Medicare Preferred PPO** |
| • Outpatient Visits | $25 copay per visit;<br>$5 copay for group sessions | $25 copay per professional individual therapy visit; $25 copay per professional group therapy visit; $0 copay for each outpatient hospital facility individual or group therapy visit. |
| • Inpatient Detox/Hospitalization | $500 copay per admission | $500 copay per admission |
| • Transitional Residential Recovery Services/Treatment Facility/Partial Hospitalization[1] | $100 copay per admission | $25 copay per professional partial hospitalization visit<br>$0 copay per partial hospitalization facility visit |
| • Prescription Drugs | Must be obtained at Kaiser pharmacies. $10 copay for generic; $25 copay for brand-name drugs. Only formulary drugs are covered. No additional Benefit Fund coverage, except injectables, as noted on page 5. | Provided through the Fund's Prescription Drug Program. See "Prescription Drugs", below. |

**PRESCRIPTION DRUGS** (administered by Caremark®, the Fund's Pharmacy Benefits Manager, "PBM") - **for all medical plans except Kaiser Senior Advantage HMO[2]**

**You *must* fill your prescriptions a Participating Pharmacy or there is no coverage** except in certain emergency situations. For a complete list of Participating Pharmacies, go to **caremark.com**, register and login.

| | |
|---|---|
| **Annual Deductible** | None |
| **Available Supply/Pharmacies** | Up to a 90-day supply per prescription from any UFCW Participating Network Pharmacy or from the Caremark® Mail Service Pharmacy. |

| YOUR COST PER PRESCRIPTION | | |
|---|---|---|
| **Type of Medication** | **Up to a 30-Day Supply** | **90-Day Supply** |
| • Formulary Generic Drug | $10 copay | $20 copay |
| • Formulary Brand Name Drug | $25 copay | $50 copay |
| • Non-Formulary Drug | $35 copay | $70 copay |

**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 difference in price between the brand name drug and the generic drug.**

**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.[3]**

[1] Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.
[2] Kaiser Senior Advantage members must obtain their prescription drugs from Kaiser pharmacies.
[3] Some medications may not be covered unless Caremark® pre-authorizes the prescription. Some medications may require a different copay, higher or lower than what is indicated above. Caremark® will contact you if your prescribed medication falls into this category. You will have 90 days 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.

| PRESCRIPTION DRUGS - for all medical plans except Kaiser Senior Advantage HMO (Continued) | | |
|---|---|---|
| **Special Therapeutic Classes[1]** | | |
| The reduced copays listed are for maintenance medications to treat hypertension, high cholesterol, diabetes (control drugs and supplies), osteoporosis, glaucoma, and asthma (including related supplies). | | |
| **YOUR COST PER PRESCRIPTION FOR A SPECIAL THERAPEUTIC CLASS DRUG** | | |
| **Type of Medication** | **Up to a 30-Day Supply** | **90-Day Supply** |
| • Formulary Generic Drug | $7 copay | $14 copay |
| • Formulary Brand Name Drug | $15 copay | $30 copay |
| • Non-Formulary Drug | $25 copay | $50 copay |
| **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 difference in price between the brand name drug and the generic drug.** | | |
| **Participant-Submitted Claims** | | |
| Available only for emergencies and out-of-area users. Plan pays the lesser of the 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. | | |

[1] If you are taking a medication for one of the conditions shown, but it is not on the Fund's list of Therapeutic Classes, please call Caremark at 855-311-3162 to determine whether your medication is considered a Maintenance Drug.

## Retiree (Except E) Benefits Chart for Calendar Year 2022

| DENTAL (Dental coverage is optional and requires an additional monthly contribution.) | | |
|---|---|---|
| **PLAN FEATURES & BENEFITS** | **INDEMNITY DENTAL PLAN[1]** | **PREPAID DENTAL PLAN** |
| **Annual Deductible** | $50 per person / $150 per family<br>(waived for preventive and diagnostic procedures) | None |
| **Annual Benefit Maximum** | $1,800 per person[2] | None |
| **Limitations** | Only services listed in the *Dental Schedule of Allowances* are covered. The schedule is available at scufcwfunds.com/healthcare/active-participants/dentalorthodontic-care/ and from the Fund Office. | |
| **Plan Payment** | Preventive/Diagnostic: 100% of scheduled allowances<br>Basic Restorative: 80% of scheduled allowances<br>Major Restorative: 70% of scheduled allowances | **100% after required Participant copays.**<br>**Copays:** Crown/pontics $75; prosthodontics $100; endodontics $45 anterior, $90 bicuspid, $125 molar.<br>The Participant is responsible for services not listed on Schedule of Allowances, including porcelain surcharges for crowns on some teeth. |

| VISION | |
|---|---|
| Exam and materials | Plan pays up to $125 per person per calendar year[3]<br>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 BENEFIT | |
|---|---|
| **Plan Payment** | **$1,000 to $5,000 depending on retiree's retirement date**<br>Payable only upon death of the retiree, provided the retiree was eligible for Retiree Medical Plan benefits at the time of death. A claim for a death benefit must be received at the Fund Office or postmarked within one year of death. Contact the Fund Office for details. |

[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 maximum, will carry over to the following calendar year. The maximum carryover for dental expenses in any given calendar year is $900.
[3] Unused vision benefits, up to one half of the annual maximum, will carry over to the following calendar year. The maximum carryover for vision expenses in any given calendar year is $62.50.

# EXCLUDED SERVICES AND LIMITATIONS

## GENERAL EXCLUDED SERVICES AND LIMITATIONS

The following exclusions and limitations apply to Medical, Prescription Drug, Vision, and EMAP benefits, except as required by applicable Federal law. 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 medicine benefits
- Experimental or investigative services, supplies, procedures, treatments, or drugs
- Expenses directly related to a non-covered procedure, service, treatment, supply, or drug
- Services provided by an immediate relative of an eligible Participant or by members of a Participant's household, except for covered expenses that are out-of-pocket expenses to the providers (the term "immediate relative" means spouse 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.

**Third Party Liability recoveries must be assigned to the Fund, but not to exceed the amount payable by the Fund.**

## 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 medicine benefits and sterilization procedures
- Treatment of infertility, except for the initial exam and diagnostic services
- Services to reverse voluntary surgically induced infertility

# EXCLUDED SERVICES AND LIMITATIONS (Continued)

**INDEMNITY PPO MEDICAL PLAN (Continued)**

- 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 participant 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 the 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
- Habilitation services (health care services that help a person keep, learn or improve skills and functioning for daily living)
- Tobacco cessation programs
- Weight loss programs
- 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:**

- Services otherwise provided under the Indemnity PPO Medical Plan or by an HMO
- 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
- 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

# EXCLUDED SERVICES AND LIMITATIONS (Continued)

**PRESCRIPTION DRUGS (Continued)**

- Drugs that are not medically necessary for the treatment of an illness or injury, except as specifically provided, such as oral contraceptives
- Appliances or prosthetics (these may be covered under the Indemnity PPO Medical Plan or the HMO)
- Lost, stolen, broken, or spilled supplies or prescription drugs
- Services otherwise provided under the Indemnity PPO Medical Plan or the HMO
- Tobacco cessation medications

**DENTAL 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 or by an HMO
- 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.**

## Retiree (Except E) Benefits Chart for Calendar Year 2022

**TO GET 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<br>P.O. Box 6010, Cypress, California 90630-0010** | **scufcwfunds.com** |
| **PARTICIPATING UNION LOCALS** | **PHONE NUMBER** | **STREET ADDRESS** | **WEBSITE** |
| **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 | 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 West Branch St., 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:**<br>UFCW Unions and Food Employers Benefit Fund | 877-284-2320 | scufcwfunds.com | |
| **Anthem™ Blue Cross Prudent Buyer PPO and BlueCard PPO** | | 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 | |
| **Anthem™ Medicare Preferred PPO** | 833-848-8729 or 833-848-8730 | anthem.com/ca | |
| **Kaiser Permanente HMO** | 800-464-4000 | kp.org | |
| **Kaiser Senior Advantage HMO** | 800-443-0815 | kp.org/medicare | |
| **Caremark®** | 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 | |