

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE RETIREE PLAN

AS OF JANUARY 1, 2010

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CONTACT INFORMATION

Trust Fund Office	877-999-8329	www.ufcwdrugtrust.org
Blue Cross Prudent Buyer	800-227-3641	www.bluecrossca.com/ca/home.html
The BlueCard Program	800- 810-BLUE (800-810-2583)	www.bluecross.com
Prescription Solutions	800-788-7871	www.rxsolutions.com
Health Management Concepts, Inc.	866-268-2510	www.APSWorkLife.com [Login: SCDBF, Passcode: EMAP]
United Concordia	800-937-6432	www.unitedconcordia.com
Podiatry Plan of California (PPOC)	800-367-7762	www.podiatryplan.com

MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE	
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Medicare
Preferred Provider Network	<p>If you live in California, your preferred provider network ("PPO") is <u>the California Blue Cross Prudent Buyer network</u>.</p> <p>If you or your dependents live outside of California, or if you are traveling outside California, your PPO network of hospitals and doctors is <u>the National BlueCard network</u>. The <u>BlueCard network</u> is available in all 50 states.</p> <p>You are strongly encouraged to use a PPO provider. The Plan pays a higher level of benefits when you use a PPO physician or hospital. You may choose to use hospitals and physicians who do not belong to the PPO networks. However, the Plan pays a lower level of benefits for non-PPO providers, and you will have higher out-of-pocket expenses.</p> <p>To find a PPO doctor or hospital nearest you, call Blue Cross Prudent Buyer at 800-227-3641 or BlueCard Access at 800-810-BLUE.</p>		<p>You must use an HMO provider. Services rendered by non-HMO providers are not covered.</p> <p>If emergency occurs outside of HMO service areas, emergency procedures and benefits apply.</p>	

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MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE	
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Medicare
How the Plan works	<p>For visits to a PPO doctor, the Plan pays 100% of the contracted rate after you pay a \$20 copay per visit.</p> <p>Before the Plan pays other benefits, you must satisfy the Calendar Year Deductible. The expenses you pay for using a PPO provider, except copayments for office visits and hospital stays, will apply toward the PPO deductible. The expenses you pay for using a non-PPO Provider, except for copayments for hospital stays and charges that exceed the Allowed Amounts¹, will apply toward the non-PPO deductible.</p> <p>After the required Calendar Year Deductible is satisfied, the Plan generally pays 80% of Contract Rates² if you use a PPO provider and 50% of the Allowed Amount if you use a non-PPO provider. For some services and supplies, specific dollar limits are imposed that result in the Fund paying less than these percentages.</p> <p>For hospital stays, you must first pay a \$100 copayment per admission. When you use a PPO provider, you are responsible for the remaining 20% of Contract Rates. When you use a non-PPO provider, you are responsible for the remaining 50% of the Allowed Amount and for any charges that exceed the Allowed Amount.</p> <p>For PPO providers, once your out-of-pocket expenses have accumulated to the calendar year out-of-pocket maximum, the Plan will pay 100% of Contract Rates for the remainder of the calendar year. Your Calendar Year Deductible and copayments for PPO office visits and hospital stays do not count toward the out-of-pocket maximum.</p> <p>There is no limit on out-of-pocket expenses when you use a non-PPO provider.</p>		<p>You pay a copay of \$25 for each office visit and \$500 for each inpatient hospital stay.</p>	<p>For Kaiser, you pay a copay of \$20 for each office visit and \$500 for each inpatient hospital stay.</p> <p>For UnitedHealthcare, you pay a copay of \$20 for each office visit and \$500 for each inpatient hospital stay.</p>
			<p>Once you have paid the Calendar Year Copayment Maximum, all care will generally be covered in full. You must keep records (receipts) of your copayments as proof. The HMOs do not keep a record of your copayments.</p>	

¹ In most cases, the Allowed Amount is the allowance that the Fund has determined is an appropriate payment for the Medically Necessary service(s) rendered to the participant in the provider's geographic area. Where the provider's charge is less than the Fund's allowance for the service(s) provided, the Allowed Amount is the provider's billed amount. The Board of Trustees, or its designee, has discretion to determine the Allowed Amount.

² The amount that the PPO Provider (Prudent Buyer Network or the BlueCard Program) has agreed by contract to accept for the services provided.

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	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Medicare
Coordination with Medicare	<p>Members who are eligible for Medicare must enroll with Medicare. The Plan does not pay for the Part B premium.</p> <p>The Fund coordinates with Medicare. Under the Retiree Plan, Medicare typically pays first, and the Plan pays for the out-of-pocket expenses that you would incur under the original Medicare plan, such as the Part A and Part B deductibles, your coinsurance for hospitalization and skilled nursing, and the 20% Part B coinsurance.</p> <p>For services by a PPO facility in California, the Plan pays the lesser of (1) the Medicare deductibles/coinsurance or (2) the difference between the PPO contract rate and the Medicare payment.</p> <p>If a Medicare-eligible participant is covered under any other plan as an active employee or as a dependent of an active employee, that coverage would pay first, Medicare second, and the Trust Fund third.</p> <p>The Plan does not pay for mental health, vision services, hearing aids, lab and x-rays related to physical exams, podiatry, orthotics, orthopedic appliances, artificial limbs, and colostomy supplies because these services are not covered under the Fund (although they may be paid by Medicare).</p>		<p>Kaiser Senior Advantage and UnitedHealthcare Secure Horizons are Medicare Advantage with Prescription Drug Plans (“MA-PD Plans”). You must enroll with Medicare and assign your Part A, Part B, and Part D benefits to the MA-PD Plan. MA-PD Plans work like HMOs. You pay the applicable copayment for covered services.</p>	
Calendar Year Deductible	\$250 per person, \$500 per family; may not be satisfied by office visit and hospital copayments.	\$500 per person, \$1,000 per family; may not be satisfied by hospital copayments or charges that exceed the Fund's Allowed Amounts.	Not applicable.	
Out-of-pocket Maximum Per Calendar Year (“OOP Maximum”)	After Calendar Year Deductible, \$2,000 per person, \$6,000 per family. Office visit and hospital copayments do not apply toward OOP maximum.	No maximum.	<p>Copayment Maximums are:</p> <p>For Kaiser, \$1,500 per person, \$3,000 per family.</p> <p>For UnitedHealthcare, \$1,500 per person, \$4,500 per family.</p>	
Lifetime Maximum	\$1,000,000 per person; \$2,000,000 per family		Unlimited.	

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	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE	
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Medicare
Plan Coinsurance	After you have satisfied the Calendar Year Deductible, the Plan pays 80% of Contract Rates for most services. Refer to each benefit below for exceptions. You are responsible for the balance.	After you have satisfied the Calendar Year Deductible, the Plan pays 50% of the Allowed Amount for most services. Refer to each benefit below for exceptions. You are responsible for the balance of the provider bill. Non-PPO providers often charge more than the Plan's Allowed Amount. When that happens, you are responsible for 50% of the Allowed Amount and 100% of any amount that exceeds the Allowed Amount.	Not applicable.	
HOSPITAL BENEFITS				
Hospital Inpatient Services (including Room and Board, and Ancillary Services)	After Calendar Year Deductible and \$100 copay per admission, the Plan pays 80% of Contract Rates. Prudent Buyer/BlueCard providers are responsible for obtaining all Utilization Review. Copayment does not count toward calendar year deductible or OOP maximum.	After Calendar Year Deductible and \$100 copay per admission, the Plan pays 50% of the Allowed Amount. All hospital admissions, except for childbirth or emergency hospitalizations, must be pre-authorized by Prudent Buyer/BlueCard. Call 800-227-3641 for pre-authorization. Benefits will be reduced if you fail to obtain required Pre-Authorization Copayment does not count toward calendar year deductible.	\$500 copay per admission.	

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	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE	
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Medicare
Skilled Nursing Facility (Medicare approved)	<p>After Calendar Year Deductible, the Plan pays 80% of Contract Rates after \$100 copay per admission, unless transferred directly from a hospital.</p> <p>Copayment does not count toward Calendar Year Deductible or OOP maximum.</p>	<p>After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount after \$100 copay per admission, unless transferred directly from a hospital.</p> <p>Copayment does not count toward Calendar Year Deductible.</p>	<p>As prescribed at designated facilities. 100% covered.</p> <p>For Kaiser, limited to 100 days per benefit period.</p> <p>For UnitedHealthcare, limited to 100 days per calendar year from the first treatment per disability.</p>	
	<p>Must be pre-authorized by Prudent Buyer/BlueCard. Limited to 240 days per disability. For Medicare members, the Plan covers the per-diem copayment for days 21 to 100. Check www.Medicare.gov for current copayment amount.</p>			
Ambulance	<p>After the Calendar year Deductible, the Plan pays 80% of Contract Rates/Allowed Amount if admitted or if the definition of “emergency” is satisfied; otherwise 50% of Contract Rates/Allowed Amount.</p>		<p>100% covered if authorized.</p>	
Emergency Room (Facility and Physician)	<p>After Calendar Year Deductible, the Plan pays 80% of Contract Rates.</p>	<p>After Calendar Year Deductible, if the definition of “emergency” is satisfied, the Plan pays 80% of the Allowed Amount; otherwise 50% of the Allowed Amount after Deductible.</p>	<p>\$100 copay, waived if admitted as inpatient.</p>	<p>\$50 copay, waived if admitted as inpatient.</p>
	<p>Determination of PPO versus non-PPO will be made based on the status of the hospital.</p>		<p>Reasonable charges for emergency services received outside HMO service areas are covered, subject to copayments.</p>	
Urgent Care Visits (After-hour office visits)	<p>\$20 copay per visit, not subject to the deductible. Copayment does not count toward Calendar Year Deductible or OOP maximum.</p>	<p>After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.</p>	<p>For Kaiser, \$25 copay.</p> <p>For UnitedHealthcare, \$25 copay for UHC provider; \$50 copay for non-UHC providers.</p>	<p>\$20 copay.</p>

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	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE	
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Medicare
Hospital Outpatient Facility Charges	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	For Kaiser , \$20 copay per visit for Medicare Retirees and \$25 copay per visit for Non-Medicare Retirees. For UnitedHealthcare , 100% covered.	
Outpatient Surgical Centers	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays a maximum of \$350 per surgery. Charges in excess of this maximum do not count toward the Deductible.	For Kaiser , \$20 copay per procedure for Medicare Retirees and \$25 copay per procedure for Non-Medicare Retirees. For UnitedHealthcare , 100% covered.	
	Must be pre-authorized by Prudent Buyer/BlueCard.			
Physician Hospital Visits	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	100% covered.	
PROFESSIONAL SERVICES				
Physician and Specialist Office Visits	\$20 copay per visit, not subject to the Deductible. Copayment does not count toward Calendar Year Deductible or OOP Maximum.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	\$25 copay per visit.	\$20 copay per visit.
Surgeon, Assistant Surgeon, & Anesthetist	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	100% covered	
Outpatient X-ray and Laboratory	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	100% covered.	
	Not covered for physical exam purposes.			

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	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE	
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Medicare
Injections	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	Office visit copay may apply.	
	Must be supplied and administered by Physician's office. Self-injectables are covered under Prescription Drug benefits.			
Physical Therapy Visits	After Calendar Year Deductible, the Plan pays 80% of Contract Rates. Pre-Authorization Required.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount. Pre-Authorization Required.	\$25 copay per visit.	\$20 copay per visit.
	Benefit payment is limited to \$2,500 per calendar year. Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity.			
Speech Therapy Visits	\$20 copay per visit, not subject to the Deductible. Limited to 24 visits per calendar year. Pre-Authorization Required. Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity.	Not covered.	\$25 copay per visit.	\$20 copay per visit.
Chiropractic Care and Acupuncture	Plan pays \$25.50 benefit per visit, one visit per day, up to a combined maximum of \$500 per calendar year for office visits and \$150 per calendar year for x-ray and laboratory. If not provided by a PPO provider, acupuncture is only covered when performed by a M.D.		Not covered.	For Senior Advantage , Not covered, except manual manipulations to correct subluxation, if covered by Medicare. For Secure Horizons , \$20 copay, up to 12 visits maximum per calendar year.
Additional Accidental Injury Benefit	In addition to other Plan benefits, a maximum of \$300 is payable for Contract Rates/Allowed Amounts of all Medically Necessary services and supplies incurred within 90 days of an accident as a result of the accident.		Not applicable.	

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	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE	
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Medicare
Reconstructive Surgery Following Mastectomy	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	\$500 copay per admission.	
	Reconstruction of the breast on which a mastectomy is performed, surgery on the other breast to provide a symmetrical appearance, and prostheses and services in connection with physical complications of all stages of mastectomy, including lymphedemas.			
Organ and Tissue Transplants	Covered only if transplant is performed at an Anthem Blue Cross approved Center of Expertise, the transplant recipient is a plan participant, and the transplant is pre-authorized. Subject to Deductible and plan coinsurance. Under certain circumstances, donor search, organ or tissue procurement, and donor expenses are covered up to a combined lifetime maximum of \$30,000.	Not covered.	Must have referral to transplant facility. Subject to plan copayments and coverage.	
Podiatry	You must use a podiatrist on the Podiatry Plan Organization of California (PPOC) panel. You pay a \$65 charge for the first office visit unless visit is for emergency, trauma, or a diabetic condition. The Plan pays 100% of Contract Rates thereafter, up to \$300 per calendar year. No benefits are paid for non-PPOC podiatrists. Outside California, use the BlueCard network.	Not covered.	\$25 copay per visit, if referred by your primary care physician to a podiatrist.	\$20 copay per visit, if referred by your primary care physician to a podiatrist.

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MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE	
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Medicare
Home Health Care	Registered nurse expenses or licensed vocational nurse when prescribed by a physician as being Medically Necessary covered at 68%. Services and supplies provided in lieu of the services that would have been covered under the plan if confinement had been in a hospital or convalescent facility are covered. Homemaker services are not covered.		For Kaiser , 100% covered, limited to 100 visits per calendar year. For UnitedHealthcare , 100% covered, limited to 100 visits per calendar year.	100% covered.
Vision Care	Not covered.		\$25 copay for eye examination.	\$20 copay for eye examination. For Secure Horizons , \$75 frame allowance every 24 months. For Senior Advantage , \$150 allowance for material every 24 months when prescribed by a Plan Physician or Plan optometrist.
PREVENTIVE MEDICINE				
Physical Examination	For doctor's examination, \$20 copay per visit, not subject to the Deductible. Copayment does not count toward Calendar Year Deductible or OOP maximum.	The Plan pays 50% of the Allowed Amount up to \$60 maximum per calendar year for doctor's examination. Age and frequency limits apply.	\$25 copay per visit.	no copay.
	Outpatient x-ray and laboratory are not covered for physical exam purposes.			
Pap & Pelvic Exam	\$20 copay per visit, not subject to the Deductible. Copayment does not count toward Calendar Year Deductible or OOP maximum.	After deductible, the Plan pays 50% of the Allowed Amount.	\$25 copay per visit.	\$20 copay per visit.

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	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Medicare
Well Child Care	\$20 copay per visit, not subject to the Deductible. Copayment does not count toward Calendar Year Deductible or OOP maximum. For age 6 or under only.	After deductible, the Plan pays 50% of the Allowed Amount up to \$200 maximum per year until age 2, combined with Immunization.	For Kaiser , \$15 copay per visit. For UnitedHealthcare , No copayment for child under 2 years old.	No copayment for child under 2 years old..
Immunization	After Calendar Year Deductible, the Plan pays 80% of Contract Rates. Must be for age 6 or under. If over age 6, only immunizations for school are covered.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount, up to \$200 maximum per year until age 2, combined with Well Child Care. If age 2 and over, only immunizations for school are covered.	\$25 copay per visit.	\$20 copay per visit.
MEDICAL SUPPLIES AND EQUIPMENT				
Outpatient Medical & Surgical Supplies	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount up to \$21.25 maximum.	100% covered.	
Durable Medical Equipment	The Plan pays 68% of Contract Rates.	The Plan pays 68% of the Allowed Amount.	<p>For Kaiser Medicare Retirees: Covered for home use in accordance with Kaiser's durable medical equipment formulary guidelines.</p> <p>For Kaiser Non-Medicare Retirees: Only Knox Keene mandated items and Basic Health Plan list items are covered.</p> <p>For UnitedHealthcare, 100% covered during a stay in a hospital or Skilled Nursing Facility.</p>	

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CHEMICAL DEPENDENCY BENEFITS

	INDEMNITY MEDICAL PLAN	UNITEDHEALTHCARE	KAISER
Under Age 65	<p>Coverage is provided through the Employee Member Assistance Program (EMAP) administered by Health Management Concepts. (HMC).</p> <p>All services and treatments must be pre-authorized by HMC and provided by APS network providers. No coverage for services and treatments by non-HMC approved providers.</p> <p>Detoxification: 100% of HMC/APS Contract Rates.</p> <p>Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program: Covered as mental health; subject to the PPO Calendar Year Deductible, Coinsurance, office visit copay, and inpatient hospital copay under the Indemnity Medical Plan (see pages 4-9), up to 3 treatments per lifetime. The second treatment must be at least 6 months after discharge from the first treatment. The third treatment must be at least 2 years after discharge from the second treatment.</p>	<p>Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program: Covered as mental health; up to 3 treatments per lifetime. The second treatment must be at least 6 months after discharge from the first treatment. The third treatment must be at least 2 years after discharge from the second treatment.</p>	<p>Coverage is provided through Kaiser. Participants must use Kaiser facilities and providers.</p> <p>Inpatient Detoxification: \$500 copay.</p> <p>Transitional Residential Recovery Services: \$100 copay per admission, up to 60 days per calendar year not to exceed 120 days in 5 calendar years.</p> <p>Outpatient Therapy: \$25 copay per individual session, or \$5 copay per group session.</p>
Age 65 and Over	<p>Same coverage as for Under Age 65 participants (see above).</p>	<p>Provided through UnitedHealthcare Secure Horizons. Participants must use Secure Horizons contract facilities and providers.</p> <p>Inpatient Detoxification: \$500 copay per admission for the first 3 admissions in each calendar year.</p> <p>Outpatient Therapy: \$20 copay per visit.</p>	<p>Provided through Kaiser. Participants must use Senior Advantage contract facilities and providers.</p> <p>Inpatient Detoxification: \$500 copay.</p> <p>Transitional Residential Recovery Services: \$100 copay per admission, up to 60 days per calendar year not to exceed 120 days in 5 calendar years.</p> <p>Outpatient Therapy: \$20 copay per individual session, or \$5 copay per group session.</p>

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PRESCRIPTION DRUG BENEFITS

	INDEMNITY PLAN	UNITEDHEALTHCARE & KAISER	
		Non-Medicare	Medicare
Participating Pharmacy	All Participants must use Prescription Solutions' pharmacies.	Participants must use the HMO's pharmacies.	
Calendar Year Deductible	\$50 per person.	None.	
Maximum Days Supply	Maximum 30 days supply per prescription. For maintenance drugs in certain therapeutic classifications, a 90-day supply may be obtained.	Maximum 30 days supply per prescription. For a maintenance drug, a 100-day supply for Kaiser or a 90-day supply for UnitedHealthcare may be obtained with two copays through mail order.	
Generics	After deductible, \$8 copay per prescription.	For Senior Advantage , \$10 copay per prescription. For Secure Horizons , \$15 copay per prescription.	
Formulary Brand	After deductible, \$20 copay per prescription if no generic equivalent is available or if your doctor indicates “dispense as written.” If a generic equivalent is available and your doctor does not indicate “dispense as written,” you must pay the cost difference between the generic drug and the brand-name drug plus the \$20 copay.	\$25 copay per prescription.	
Non-formulary Brand	After deductible, \$35 copay per prescription.	For Senior Advantage , not covered. For Secure Horizons , \$40 copay per prescription.	
Injectables	After deductible, 80% of Prescription Solutions' Contract Rate. Authorization required through Prescription Solutions.	Certain injectables are covered.	
Maximum Benefit	\$25,000 per person per calendar year.	No maximum.	
Medicare Part D (Medicare eligible retirees only)	If you or your spouse enroll in an individual Medicare Part D plan, you will lose prescription drug coverage under the Retiree Health Plan.	If you or your spouse enroll in an individual Medicare Part D plan, the HMO will terminate your coverage and you and your eligible dependents will be transferred into the Indemnity Medical Plan provided by the Retiree Health Plan. Under the Indemnity Medical Plan, Prescription drug coverage will not be available for retirees and/or dependents who have enrolled in an individual Medicare Part D Plan.	

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE RETIREE PLAN AS OF JANUARY 1, 2010

This summary shows the "100% coverage" level of benefits. Refer to the Levels of Coverage section on page 8 of the Summary Plan Description for Retirees and their Dependents to determine your percentage and how that percentage is applied to your benefits under the Fund plans.

MEDICAL PLAN EXCLUSIONS

	INDEMNITY PLAN	KAISER & UNITEDHEALTHCARE
<p>Excluded Services</p>	<ul style="list-style-type: none"> » Replacement of artificial eyes; » Orthognathic surgery; » Dental Care and dental x-rays, except for dental tumors; » Orthodontic care; » Cosmetic treatment or surgery and complications resulting from any such procedure, except for repair of damage caused by accidental bodily injury while eligible under the plan (restorative surgery performed during or following mutilative surgery which was required as a result of illness or injury shall not be considered cosmetic); » Charges made by relatives of anyone in the Participant's household, except for covered charges which constitute out-of-pocket expenses to such providers; » Eye examinations including refractions and fitting of glasses, hearing aids, health aids, artificial limbs, and orthopedic appliances, except as specifically covered; » Custodial care regardless of the type of facility and/or provider; » Experimental treatment, procedures and therapies and any complications arising from such treatment; » Any supplies or services furnished by a hospital or facility operated by the U.S. Government or any authorized agency thereof, or furnished at the expense of such Government or agency; » Any expenses connected with any form of artificial insemination, any non-surgical treatment for infertility after diagnosis, any expenses connected with or resulting from surrogate mothers or sperm banks, or the reversal of voluntary infertility; » Services and supplies for which no charge is made, or for which one is not required to pay; » Any services or supplies not recommended and approved by a legally qualified physician or surgeon, dentist, mental health professional, podiatrist on the PPOC panel, or chiropractor performing services within the legal scope of their practices; » Conditions covered by Workers' Compensation or incurred in the course of employment, including self-employment; » Speech therapy, except from a PPO provider; 	<p>Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare.</p>

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MEDICAL PLAN EXCLUSIONS

	INDEMNITY PLAN	KAISER & UNITEDHEALTHCARE
<p>Excluded Services (cont'd)</p>	<ul style="list-style-type: none"> » Penile prosthesis except when the cause of impotence is organic and then only if Pre-Authorized; » Pregnancy expenses of dependent children or expenses for conditions arising from pregnancy of dependent children; » Surgical correction of refractive problems including radial keratotomy unless vision cannot be corrected through eyeglasses or contact lenses; » Any treatment or procedure designed to alter physical characteristics of the covered individual to those of the opposite sex and any other treatment or studies related to sex transformations, sex change counseling, treatment or surgery; » Expenses incurred for any condition where there exists no injury or sickness, except that this exclusion does not apply to benefits specifically provided, such as hospice care, sterilization procedures, and preventive care benefits; » Treatment of nervous or mental disorders; » Take home drugs when discharged from the hospital; » Charges in excess of Contract Rates; or, as applicable, the Allowed Amount; » Organ or tissue transplants performed at a facility that is not an Anthem Blue Cross Center of Expertise; » Expenses incurred by an organ or tissue donor when the transplant recipient is not a plan participant. » Expenses incurred by a transplant donor who is not eligible under the plan (except for benefits specifically provided); » Vocational testing, evaluation and counseling; » Injuries resulting from any form of warfare or invasion; » No benefits will be provided for podiatric care received from a non-PPOC podiatrist (if you live outside of California no podiatry benefits will be provided unless you use a BlueCard network podiatrist). In addition, benefits for podiatric care are limited to those specifically described; » Hearing aids, artificial limbs, orthotics, orthopedic appliances, and colostomy supplies; » Lab and x-rays related to physical exams; 	<p>Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare.</p>

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MEDICAL PLAN EXCLUSIONS

	INDEMNITY PLAN	KAISER & UNITEDHEALTHCARE
Excluded Services (cont'd)	<ul style="list-style-type: none"> » Claims filed more than one year after the date on which services were incurred; » Services or supplies that are not Necessary Treatment. » For Prescription Drug exclusions, please contact the Fund Office. 	Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare.
Amendment of Plan	<p>All terms of the Retiree Health Plan are subject to amendment by the Board of Trustees or by the Unions and Retail Drug Employers. Benefits under the prepaid medical programs (HMOs) are also subject to amendments by the Trustees, the Unions and Employers, and the HMOs themselves. Benefits under the Plan are not vested. The continuation of retiree benefits depends on the continuation of Collective Bargaining Agreements which require Employers to make contributions for these benefits.</p> <p>Benefits will be continued to the extent that the Employer contributions provide for financing of these benefits. If contributions become insufficient to pay for all Plan benefits, benefits may be reduced or eliminated or the eligibility rules may be changed. Future Collective Bargaining Agreements may terminate the Plan.</p>	
Third Party Liability	If a Participant obtains a recovery from a third party that is in any manner related to claims paid by the Trust, the Participant will reimburse the Trusts from such recovery in an amount not in excess of the payments made or to be made by the Trust.	Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare

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