



**SOUTHERN CALIFORNIA DRUG BENEFIT FUND
PLATINUM PLAN SUMMARY – STATER BROTHERS MARKETS
AS OF JANUARY 1, 2011**

**SOUTHERN CALIFORNIA DRUG BENEFIT FUND
PLATINUM PLAN SUMMARY AS OF JANUARY 1, 2011**

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CONTACT INFORMATION

Trust Fund Office	877-999-8329	www.ufcwdrugtrust.org
Anthem Blue Cross Prudent Buyer	800-227-3641	www.anthem.com/ca/home/html
The BlueCard Program	800- 810-BLUE (800-810-2583)	www.bluecross.com
Delta Dental	800-765-6003	www.deltadentalins.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

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ELIGIBILITY RULES

ESTABLISHING ELIGIBILITY & COVERAGE COMMENCEMENT	
All Employees	<p>If you work an average of 23 or more hours per week (“Qualifying Hours”) for 3 consecutive months, you and your dependents will become eligible for coverage on the first day of the month after 2 skip months. For example, if you work Qualifying Hours in January, February and March, you will be eligible for benefits on June 1.</p> <p>Newly eligible employees are required to enroll in the Indemnity Medical Plan. You will be eligible to enroll in an HMO plan on the 4th annual open enrollment after your date of hire.</p> <p>You may choose the Indemnity Dental Plan or the United Concordia Pre-Paid Dental Plan.</p>
Coordination of Benefits Rule for Spouses	<p>If you are married and enrolled in the Indemnity Medical Plan, and if your spouse’s employer offers health care coverage, your spouse <u>must</u> enroll in that employer’s plan, even if your spouse is required to contribute toward the cost of that coverage. If your spouse has other coverage available to him or her, the Indemnity Medical Plan will pay claims in accordance with its Coordination of Benefits Rule as though your spouse had enrolled in the best coverage available through his or her own employment, whether or not your spouse is actually enrolled in that other coverage. This means that the Indemnity Medical Plan will not pay any benefits for charges that would have been covered under that other plan.</p>
MAINTAINING ELIGIBILITY	
All Employees	<p>Once you become eligible, you must continue to work the Qualifying Hours during each month to maintain your eligibility, to establish eligibility for other benefits, and to establish and/or maintain eligibility for your dependents.</p>

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MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	
How the Plan works	<p>Generally, you must satisfy the Calendar Year Deductible before the Plan pays any benefits. 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 Amounts, will apply toward the non-PPO Deductible.</p> <p>After the required Calendar Year Deductible is satisfied, the Plan pays 80% of Contract Rates¹ if you use a PPO provider and 50% of the Allowed Amount² 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 you are also responsible for any charges that exceed the Allowed Amount.</p> <p>PPO office visits are not subject to the PPO Calendar Year Deductible. The Plan pays 100% of the contracted rate after you pay a \$20 copay per visit.</p> <p>Effective January 1, 2009, when you use a <u>PPO</u> provider for preventive and wellness services, the Plan will pay 100% of Contract Rates for all of the preventive care and immunization services listed in the Plan's current Preventive Care Guidelines, which are available from the Fund Office. There is no Deductible and no copayment as long as services are received from PPO providers.</p> <p>For PPO services, once your out-of-pocket expenses have accumulated to the calendar year out-of-pocket maximum, the Plan will pay 100% of Contracted 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>For most services, you pay a copay every time you use the service. Generally, the copays are \$25 for office visits, \$100 for emergency room visits, and \$500 for hospital admissions.</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. Kaiser and UnitedHealthcare do not keep a record of your copayments.</p>

¹ 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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MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	
Preferred Provider Network (PPO)	<p>If you live in California, your preferred provider network (“PPO”) is <u>the California Anthem 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</u> network 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 provider nearest you, call Anthem 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 an emergency occurs outside of the HMOs’ service areas, emergency procedures and benefits apply.</p>
Calendar Year Deductible	\$250 per person, \$500 per family; may not be satisfied by office visit or 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.
Plan Coinsurance	<p>After you have satisfied the Calendar Year Deductible, the Plan pays 80% of Contract Rates for most services. You are responsible for the remaining 20% of Contract Rates. Refer to each benefit below for exceptions.</p> <p>The Plan will pay 100% of Contract Rates after you reach the out-of-pocket maximum for the calendar year.</p>	<p>After you have satisfied the Calendar Year Deductible, the Plan pays 50% of the Allowed Amount for most services. 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.</p>	Not applicable.

² 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.

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	PPO (In Network)	Non-PPO (Out of Network)	
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.	Copayment Maximums are: For Kaiser , \$1,500 per person, \$3,000 per family. For UnitedHealthcare , \$1,500 per person, \$4,500 per family.
Lifetime Maximum	\$1,000,000 per person; \$2,000,000 per family		Unlimited.
Pre-Authorization and Utilization Review	When Pre-authorization or Utilization Review is required, your doctor or other provider must contact Prudent Buyer/BlueCard at 800-274-7767. Contracted hospitals will do this automatically. You should confirm that your other providers, including non-PPO hospitals, have done this.		Kaiser: Not Applicable United Healthcare: See UnitedHealthcare’s Evidence of Coverage.
HOSPITAL BENEFITS			
Hospital Inpatient Services (Including Room and Board, and Ancillary Services)	After the Calendar Year Deductible and \$100 copay per admission, the Plan pays 80% of Contract Rates. Prudent Buyer/BlueCard providers are responsible for obtaining all Pre-Authorization and Utilization Review. Copayment does not count toward Calendar Year Deductible or OOP Maximum.	After the 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 <u>800-274-7767</u> 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.
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.	100% covered. For Kaiser , \$25 copay per visit.

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	PPO (In Network)	Non-PPO (Out of Network)	
Skilled Nursing Facility (Medicare approved)	After Calendar Year Deductible, the Plan pays 80% of Contract Rates. Must be Pre-Authorized by Prudent Buyer/BlueCard. Limited to 240 days per disability.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	As prescribed at designated facilities. 100% covered. For Kaiser , limited to 100 days per benefit period. For UnitedHealthcare , limited to 100 consecutive days per calendar year from the first treatment per disability.
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.
Outpatient Surgical Centers	After Calendar Year Deductible, the Plan pays 80% of Contract Rates. Must be Pre-Authorized by Prudent Buyer/BlueCard.	After Calendar Year Deductible, the Plan pays a maximum of \$350 per surgery. Any charges in excess of this maximum do not count toward the Deductible or OOP Maximum. Must be Pre-Authorized by Prudent Buyer/BlueCard.	100% covered.
Emergency Room (Facility and Physician)	After Calendar Year Deductible, the Plan pays 80% of Contract Rates. Determination of PPO versus non-PPO will be made based on the status of the hospital.	After Calendar Year Deductible, if the definition of "emergency" is satisfied, the Plan pays 80% of the Amount Allowed; otherwise 50% of the Amount Allowed after Deductible.	\$100 copay, waived if admitted as inpatient. Reasonable charges for emergency services received outside HMO service areas are covered, subject to deductibles and copayments.
Ambulance	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/Amount Allowed.		100% covered if authorized.

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PROFESSIONAL SERVICES			
Preventive Care	Plan pays 100% of Contract Rates, not subject to the Calendar Year Deductible and no copayment is required.	After Calendar Year Deductible, Plan pays 50% of the Allowed Amount.	\$25 copay per visit in general, except the following under Kaiser : <ul style="list-style-type: none"> ▪ \$15 copay per visit for Well Child Care. ▪ 100% covered for Immunization.
	Coverage is provided for the services, screenings, and exams listed in, and subject to the frequency described in, the Drug Benefit Fund's Preventive Care Guidelines. In cases where increased risk requires more frequent screenings, the determination of increased risk is made by the physician in accordance with the U.S. Preventive Services Taskforce and/or the recommendations of the American Academy of Family Physicians.		
Physician and Specialist Office Visits, Urgent Care	\$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. For UnitedHealthcare , \$50 copay for urgent care.
Surgeon, Assistant Surgeon, & Anesthetist	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of 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.
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. Preauthorization is required.	\$25 copay per visit.
	Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity. Benefit payment is limited to a maximum of \$2,500 per calendar year.		

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	PPO (In Network)	Non-PPO (Out of Network)	
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.
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.
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.
Special Podiatry Benefit	A separate \$120 calendar year benefit is available regardless of whether you are enrolled in Kaiser, UnitedHealthcare, or the Indemnity Medical Plan. The benefit is for office calls and charges, including x-rays, incurred for the non-surgical treatment of chronic foot conditions such as weak or fallen arches, flat or pronated feet, hallux valgus, metatarsalgia, or foot strain and toenail trimming and surgical treatment involving debridement of painful clavi.		
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.		

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Obesity Bypass Surgery	Covered under the Hospital and Surgical benefits if Pre-Authorized as Medically Necessary.		Covered if determined Medically Necessary and authorized.
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.
Vision Care	A \$135 maximum benefit for eye refractions and/or frames and lenses each calendar year. For Kaiser or UnitedHealthcare, if eye exam is obtained through the HMO, there is a \$25 copay for the exam and the \$135 Indemnity Plan benefit can be used for frames or lenses.		
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.
Home Health Care	Registered nurse expenses or licensed vocational nurse when prescribed by a physician as being Medically Necessary are covered at 80%. Pre-Authorization by Prudent Buyer / BlueCard is required. 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 Skilled Nursing Facility are covered. Homemaker services are not covered.		For Kaiser, 100% covered up to 100 2-hour visits per calendar year. For UnitedHealthcare, 100% covered up to 100 visits per calendar year.
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.

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MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	
Orthopedic Appliances	Reimbursement of 100% of Contract Rates or Allowed Amount for purchase or rental prescribed by a physician, up to once every calendar year.		
Hearing Aids	For patients whose physician has certified a hearing loss that may be lessened by the use of a hearing aid. The Plan pays 80% of the Allowed Amount for physician examination and instrument up to \$750 maximum for each ear, not more often than once during any 12-month period.		
Durable Medical Equipment	The Plan pays 80% of Contract Rates.	The Plan pays 80% of the Allowed Amount.	<p>100% covered during a stay in a hospital or Skilled Nursing Facility.</p> <p>For Kaiser, Covered durable medical equipment for home use in accord with Kaiser's durable medical equipment formulary guidelines.</p> <p>For UnitedHealthcare, \$5,000 maximum per calendar year.</p>

PRESCRIPTION DRUG BENEFITS

Participating Pharmacy	All Participants must use Prescription Solutions' pharmacies. (See separate Directory at www.ufcwdrugtrust.org under "Downloads")
Calendar Year Deductible	None.
Maximum Days Supply	Maximum 30 days supply per prescription. For maintenance drugs in certain therapeutic classifications, a 90-day supply may be obtained.
Generics	\$8 copay per prescription.
Formulary Brand	\$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.
Non-formulary Brand	\$35 copay per prescription.

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PRESCRIPTION DRUG BENEFITS

Injectables	The Plan Pays 80% of Prescription Solutions' Contract Rate. Authorization required through Prescription Solutions.
Maximum Benefit	\$25,000 per person per calendar year.

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS

	INDEMNITY MEDICAL PLAN	UNITEDHEALTHCARE	KAISER
<p>Mental Health</p> <p><i>Note: For UnitedHealthcare and Kaiser, Severe mental illness and serious emotional disturbance of a child as defined by AB 88 are not subject to the maximum number of inpatient days or outpatient visits.</i></p>	<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-approved by HMC and provided by APS network providers. No coverage for services and treatments by non-HMC approved providers.</p> <hr/> <p>Coverage subject to the PPO Calendar Year Deductible under the Indemnity Medical Plan.</p> <p>Inpatient: After Deductible and \$100 copay per admission, the Plan pays 80% of HMC/APS Contract Rates up to 70 days per calendar year.</p> <p>Outpatient: \$20 copay per visit, no Deductible. Maximum 50 visits per calendar year.</p>	<p>Inpatient: \$500 copay per admission. For Non-AB 88 diagnoses, 30 days maximum per calendar year.</p> <p>Outpatient: \$25 copay per visit. For Non-AB 88 diagnoses, maximum of 20 visits per calendar year.</p>	<p>Coverage is provided through Kaiser. Participants must use Kaiser facilities and providers.</p> <p>Inpatient: \$500 copay per admission. For Non-AB 88 diagnoses, 30 days maximum per calendar year.</p> <p>Outpatient: \$25 copay per visit (\$12 copay for group visits). For Non-AB 88 diagnoses, maximum of 20 visits per calendar year.</p>

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Chemical Dependency and Substance Abuse	<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-approved by HMC and provided by APS network providers. No coverage for services and treatments by non-HMC approved providers.</p> <p>Detoxification: The Plan pays 100% of HMC/APS Contract Rate.</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>
	<p>Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program: Covered as mental health; subject to the PPO Calendar Year Deductible and Coinsurance under the Indemnity Medical Plan (see page 3), 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>	

DENTAL BENEFITS

	INDEMNITY PLAN	UNITED CONCORDIA
Choice of Provider	You may select any dentist of your choice. Using a DeltaPPO dentist will lower your out-of-pocket expenses.	You must use the United Concordia dental office in which you are enrolled.
Covered Charges	<p>For DeltaPPO dentists, the Plan pays the lesser of the DeltaPPO Contracted Rates or the amount listed in the Schedule of Allowances.</p> <p>For DeltaPremier dentists, the Plan pays the lesser of the DeltaPremier Filed Fee(s) or the amount listed in the Schedule of Allowances.</p> <p>For non-Delta Dental dentists, the Plan pays the lesser of the amount billed by the dentist or the amount listed in the Schedule of Allowances.</p> <p>Schedule of Allowances is established by the Trustees and adjusted annually (see separate schedule at www.ufcdrugtrust.org under "Downloads").</p>	United Concordia's Schedule of Benefits.

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DENTAL BENEFITS

	INDEMNITY PLAN	UNITED CONCORDIA
Calendar Year Deductible	\$75 per person; \$225 per family. Not applicable to routine preventative and diagnostic procedures.	None.
Maximum Benefit	\$1,800 per person per calendar year.	No maximum.

MEDICAL PLAN EXCLUSIONS

	INDEMNITY PLAN	KAISER & UNITED HEALTHCARE
Excluded Services	<ul style="list-style-type: none"> » Replacement of artificial eyes; » Orthognathic surgery; » 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; » Custodial care regardless of the type of facility and/or provider; 	Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare.
	<ul style="list-style-type: none"> » Eye examinations including refractions and fitting of glasses, hearing aids, health aids, artificial limbs, and orthopedic appliances, except as specifically covered; » 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 	Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare

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PLATINUM PLAN SUMMARY AS OF JANUARY 1, 2011**

MEDICAL PLAN EXCLUSIONS

	INDEMNITY PLAN	KAISER & UNITED HEALTHCARE
	<p>performing services within the legal scope of their practices;</p> <ul style="list-style-type: none"> » Conditions covered by Workers' Compensation or incurred in the course of employment, including self-employment; » 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; » Benefits for treatment of nervous or mental disorders are limited to those provided under the EMAP; » Speech therapy, except from a PPO provider; 	
Excluded Services (cont'd)	<ul style="list-style-type: none"> » 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 	<p>Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare.</p>

This document is intended merely as a summary of the Platinum health care plan offered by the Southern California Drug Benefit Fund. For exclusions and restrictions, you should read the Summary Plan Description and the evidence of coverage booklets provided by Kaiser, UnitedHealthcare (formerly PacifiCare), and United Concordia.

**SOUTHERN CALIFORNIA DRUG BENEFIT FUND
PLATINUM PLAN SUMMARY AS OF JANUARY 1, 2011**

MEDICAL PLAN EXCLUSIONS

	INDEMNITY PLAN	KAISER & UNITED HEALTHCARE
	<p>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;</p> <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 Dental Exclusions, please refer the Evidence of Coverage booklet provided by United Concordia or, if you are in the Indemnity Dental Plan please read the Indemnity Schedule of Allowances for Dental Procedures (revised annually in January). » For Prescription Drug exclusions, please contact the Fund Office. 	
Third Party Liability	<ul style="list-style-type: none"> » 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

DEATH BENEFITS

Employee	Greater of \$15,000 or the amount of salary received during the most recent 12 months.
Dependent	\$2,000

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