



**SOUTHERN CALIFORNIA DRUG BENEFIT FUND**

**PLATINUM PLAN SUMMARY**

**As of January 1, 2012**

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**CONTACT INFORMATION**

<b>Drug Trust Fund Office</b>	<b>877-999-8329</b>	<a href="http://www.ufcwdrugtrust.org">www.ufcwdrugtrust.org</a>
<b>Anthem Blue Cross Prudent Buyer</b>	<b>800-227-3641</b>	<a href="http://www.anthem.com/ca/home/html">www.anthem.com/ca/home/html</a>
<b>The BlueCard Program</b>	<b>800- 810-BLUE (800-810-2583)</b>	<a href="http://www.bluecross.com">www.bluecross.com</a>
<b>Prescription Solutions</b>	<b>800-788-7871</b>	<a href="http://www.rxsolutions.com">www.rxsolutions.com</a>
<b>Delta Dental</b>	<b>800-765-6003</b>	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>
<b>Health Management Concepts, Inc.</b>	<b>866-268-2510</b>	<a href="http://www.APSWorkLife.com">www.APSWorkLife.com</a> [Login: SCDBF, Passcode: EMAP]
<b>United Concordia</b>	<b>800-937-6432</b>	<a href="http://www.unitedconcordia.com">www.unitedconcordia.com</a>
<b>United Healthcare</b>	<b>800-624-8822</b>	<a href="http://www.uhcwest.com">www.uhcwest.com</a>
<b>Podiatry Plan of California (PPOC)</b>	<b>800-367-7762</b>	<a href="http://www.podiatryplan.com">www.podiatryplan.com</a>

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**ELIGIBILITY RULES**

<b>ESTABLISHING ELIGIBILITY &amp; COVERAGE COMMENCEMENT</b>	
<b>All Employees</b>	<p><b>Employee-only Coverage</b> – If you work an average of 23 or more hours per week (“Qualifying Hours”) for 3 consecutive months, you will become eligible to elect employee-only coverage, except prescription drug and dental benefits, 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 Employee-only medical and vision benefits on June 1 provided that you actively elect coverage by authorizing an Employee Contribution deduction from your paycheck.</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 4<sup>th</sup> annual open enrollment after your date of hire.</p> <p><b>Prescription Drug and Dental Benefits</b> – If you continue to work Qualifying Hours each month, prescription drug and dental benefits will be available to you after you have been eligible for employee-only medical and vision coverage for six months. You may choose the Indemnity Dental Plan or the United Concordia Pre-Paid Dental Plan.</p> <p><b>Dependent Coverage</b> – If you continue to work Qualifying Hours each month, your dependents become eligible for all benefits, including medical, dental, prescription drug, and vision, after you have been eligible for employee-only coverage for six months (the same month you become eligible for Prescription and Dental Coverage). Your dependents must enroll in the same medical and dental plan as you. If your hire date is on or after August 1, 2004, you are required to pay \$5.00 per week (\$21.66 per month) for dependent coverage, regardless of the number of dependents you have. Effective March 1, 2012, this requirement is being replaced by the new requirement that all Employees pay contributions towards the cost of coverage, as explained below.</p>
<b>Employee Contributions</b>	<p>Effective March 1, 2012, all Employees will be required to pay contributions towards the cost of coverage. Employee contributions will generally be paid via payroll deduction (self-pay will be available for participants for whom a payroll deduction is not taken). You must complete an authorization form to allow your Employer to deduct your contribution amount and pay it to the Fund. Monthly Employee contributions must be paid by the end of the month before the month of coverage. For example, for coverage in the month of July, your monthly contribution must be paid by the end of June. Your first monthly payment is due in March 2012 for coverage in the month of April, 2012.</p> <p>The amount of your monthly contribution is as follows:</p> <ul style="list-style-type: none"> <li>• \$30.33 per month for Employee-only coverage.</li> <li>• \$47.67 per month for Employee plus one or more children.</li> <li>• \$65.00 per month for Employee plus spouse or Domestic Partner, with or without children.</li> </ul> <p>If there is any month in which you fail to make a contribution, you will lose coverage in the corresponding coverage month.</p>

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<b>Coordination of Benefits Rule for Spouses</b>	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.
<b>MAINTAINING ELIGIBILITY</b>	
<b>All Employees</b>	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. Effective March 1, 2012, you will also be required to pay monthly contributions in order to maintain your coverage (as explained above).

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**MEDICAL BENEFITS**

	INDEMNITY PLAN		UNITED HEALTHCARE (UHC) FLEX HMO	KAISER
	PPO (In Network)	Non-PPO (Out of Network)		
<b>How the Plan works</b>	<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 copays for office visits and hospital stays, will apply toward the PPO Deductible. The expenses you pay for using a non-PPO Provider, except for copays for hospital stays and charges that exceed the Allowed Amounts apply toward the non-PPO Deductible. After the required Calendar Year Deductible is satisfied, the Plan generally pays 80% of Contract Rates<sup>1</sup> if you use a PPO provider and 50% of the Allowed Amount<sup>2</sup> 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. 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. When you use a PPO 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. There is no limit on out-of-pocket expenses when you use a non-PPO Provider.</p>		<p>Generally, you must satisfy the Calendar Year Deductible before UHC pays any benefits. The Calendar Year Deductible is \$500 per individual (\$1,000 per family). The amount you pay for most Doctors' visits depends on which network you choose. For example, if you choose Network 1, your copays will generally be \$20 for each physician office visit.</p> <p>Preventive care services, such as your annual physical exams, are covered at 100% with no copay and not subject to the Deductible.</p> <p>For most other services, UHC pays a percentage of Covered Charges<sup>3</sup> depending on which network you choose. For example, if you choose Network 1, UHC will pay 80% and you will pay 20% of Covered Charges.</p> <p>Once you have paid the Calendar Year Out-of-Pocket Maximum, all care will generally be covered in full. You must keep records (receipts) of your copayments and Coinsurance as proof of payment.</p>	<p>For most services, you pay a copay every time you use the service. However, inpatient hospital stays and outpatient surgery are subject to a Calendar Year Deductible. For inpatient hospital stays and outpatient surgeries, once you have satisfied the Deductible, Kaiser will generally pay 80% of the cost; you are responsible for the remaining 20%. Specific copays, Coinsurance and Deductible amounts are outlined below.</p> <p>Once your out-of-pocket expenses (in addition to the Calendar Year Deductible) reach the Calendar Year Out-of-Pocket Maximum, all care will generally be covered in full for the remainder of the Calendar Year.</p> <p>You must keep records (receipts) of your copayments and Coinsurance as proof of payment.</p>

<sup>1</sup> The amount that the PPO Provider has agreed by contract (with Prudent Buyer Network or the BlueCard Program) to accept for the services provided.

<sup>2</sup> 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.

<sup>3</sup> The amount that the UHC Provider has agreed by contract with UHC to accept for the services provided.

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<b>Preferred Provider Network (PPO)</b>	<p>If you live in California, your preferred provider network (“PPO”) is the <b>California Anthem Blue Cross Prudent Buyer network</b>.</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 the <b>National BlueCard network</b>. The <b>BlueCard</b> 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>There are three network choices with the UHC Flex HMO. You must choose to participate in one of the three networks during open enrollment. You and all of your dependents must be enrolled in the same network. Your out-of-pocket expenses will be the lowest if you choose Network 1. Your out-of-pocket expenses will be the highest if you choose Network 3. Once a network is chosen, you and your family members will only have access to Providers in that network. Generally, you will not be able to change networks until the next annual open enrollment (unless you or a Dependent have certain special enrollment rights). Each family member may have their own primary care physician within the chosen network.</p> <p>If you do not live within the service area of the Flex HMO, i.e. you do not have access to a PCP from Networks 1, 2, or 3, you will participate in and choose a PCP from the Signature Value Network. Your benefits will be the same as those provided under Network 1.</p> <p>Services rendered by a Provider not in your chosen network are not covered. If an emergency occurs outside of the UHC service area, emergency procedures and benefits apply.</p>	<p>You must use Kaiser providers. Services rendered by non-Kaiser providers are not covered.</p> <p>If an emergency occurs outside of the HMOs’ service areas, emergency procedures and benefits apply.</p>

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	PPO (In Network)	Non-PPO (Out of Network)		
<b>Calendar Year Deductible or "Deductible"</b>	\$500 per person, \$1,000 per family; may not be satisfied by office visit or hospital copayments.	\$1,000 per person, \$2,000 per family; may not be satisfied by hospital copayments or charges that exceed the Fund's Allowed Amounts.	\$500 per person, \$1,000 per family  Certain covered services will not be covered until you meet your Calendar Year Deductible. The Deductible applies to many services, including most inpatient services and outpatient surgery. It does not apply to preventive care, many outpatient services, emergency services or urgently needed services. Only amounts incurred for covered services that are subject to the Deductible will count towards the Deductible. For more information about which services are subject to the Deductible, please see your Evidence of Coverage from UHC.	\$500 per person, \$1,000 per family  Applies to most services. Not applicable to doctor's office visits and preventive care. See Kaiser's Evidence of Coverage for more information.
<b>Plan Coinsurance</b>	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.  The Plan will pay 100% of Contract Rates after you reach the Out-of-Pocket Maximum for the calendar year.	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.	Applies to Inpatient Hospitalization and outpatient surgery. After you satisfy the Deductible, UHC will pay:  <b>Network 1:</b> 80% of Covered Charges <b>Network 2:</b> 75% of Covered Charges <b>Network 3:</b> 70% of Covered Charges.  You are responsible for the remaining 20% - 30% of Covered Charges until you reach your annual Out-of-Pocket Maximum	After the Deductible, Kaiser will pay 80% of Covered Charges for services subject to Coinsurance. You are responsible for the remaining 20% until you reach your annual Out-of-Pocket Maximum.  Services subject to Coinsurance include, but are not limited to, Inpatient Hospitalization, Outpatient Surgery, Inpatient Mental Health, Inpatient Chemical Dependency and emergency room visits.
<b>Covered Charges</b>	Not Applicable	Not Applicable	The amount that the UHC Provider has agreed by contract with UHC to accept for the services provided.	The amount that Kaiser has determined is a reasonable charge for the service provided.

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<b>Out-of-Pocket Maximum Per Calendar Year (“OOP Maximum”)</b>	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.	After Calendar Year Deductible, \$2,000 per person, \$4,000 per family. Copayments for certain types of Covered Charges do not apply toward the Out-of-Pocket Maximum. Please refer to UHC’s Schedule of Benefits or Evidence of Coverage for more information.	\$2,000 per person, \$4,000 per family. Deductible amounts, Coinsurance and Copays may be used toward the Out-of-Pocket Maximum.
<b>Annual Benefit Limit (applies to Medical, Prescription Drug, Mental Health, Substance Abuse)</b>	\$1,250,000 per person for services incurred during the 2012 calendar year.		No limit	No limit
<b>Pre-Authorization and Utilization Review</b>	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.		See UHC’s Evidence of Coverage	Not applicable

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<b>HOSPITAL BENEFITS</b>				
<b>Hospital Inpatient Services (Including Room and Board, and Ancillary Services)</b>	<p>After the Calendar Year Deductible and \$100 copay per admission, the Plan pays 80% of Contract Rates.</p> <p>Prudent Buyer/BlueCard providers are responsible for obtaining all Pre-Authorization and Utilization Review.</p> <p>Copayment does not count toward Calendar Year Deductible or OOP Maximum.</p>	<p>After the Calendar Year Deductible and \$100 copay per admission, the Plan pays 50% of the Allowed Amount.</p> <p>All hospital admissions, except for childbirth or emergency hospitalizations, must be Pre-Authorized by Prudent Buyer/BlueCard. You must notify Anthem within 72 hours of an emergency admission. Call 800-810-BLUE for Pre-Authorization (for outside California). In California, call 800-274-7767.</p> <p>Benefits will be reduced if you fail to obtain Pre-Authorization.</p> <p>Copayment does not count toward Calendar Year Deductible.</p>	<p>After the Calendar Year Deductible, UHC pays:</p> <p><b>Network 1:</b> 80% of Covered Charges  <b>Network 2:</b> 75% of Covered Charges  <b>Network 3:</b> 70% of Covered Charges</p>	<p>After Deductible, Kaiser pays 80% of Covered Charges</p>
<b>Hospital Outpatient Facility Charges</b>	<p>After Calendar Year Deductible, the Plan pays 80% of Contract Rates.</p>	<p>After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.</p>	<p>After the Calendar Year Deductible, UHC pays:</p> <p><b>Network 1:</b> 80% of Covered Charges  <b>Network 2:</b> 75% of Covered Charges  <b>Network 3:</b> 70% of Covered Charges</p>	<p>After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges</p>

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<b>Skilled Nursing Facility (Medicare approved)</b>	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.  Coinsurance does not count toward Calendar Year Out-of-Pocket Maximum.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	After the Calendar Year Deductible, UHC pays:  <b>Network 1:</b> 80% of Covered Charges <b>Network 2:</b> 75% of Covered Charges <b>Network 3:</b> 70% of Covered Charges  Limit of 100 consecutive days per Calendar Year from the first treatment per disability.	As prescribed at designated facilities. After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges. Limited to 100 days per benefit period.
<b>Physician Hospital Visits</b>	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	After the Calendar Year Deductible, UHC pays:  <b>Network 1:</b> 80% of Covered Charges <b>Network 2:</b> 75% of Covered Charges <b>Network 3:</b> 70% of Covered Charges	After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges
<b>Outpatient Surgeries</b>	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 operative session. Any charges in excess of this maximum do not count toward the Deductible or OOP Maximum.  Must be Pre-Authorized by Prudent Buyer/BlueCard.	After the Calendar Year Deductible, UHC pays:  <b>Network 1:</b> 80% of Covered Charges <b>Network 2:</b> 75% of Covered Charges <b>Network 3:</b> 70% of Covered Charges	After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges
<b>Emergency Room Services (Facility, Physician and Ancillary Services)</b>	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, if the patient has an "emergency medical condition", the Plan pays 80% of the Allowed Amount; otherwise 50% of the Allowed Amount after Deductible.	<b>Network 1:</b> \$100 copay <b>Network 2:</b> \$150 copay <b>Network 3:</b> \$200 copay	After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges
	Determination of PPO versus non-PPO will be made based on the status of the hospital.			

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<b>Urgent Care</b>	\$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.	<b>Within Your Medical Group:</b> <b>Network 1:</b> \$20 copay <b>Network 2:</b> \$35 copay <b>Network 3:</b> \$40 copay  <b>Outside of Your Medical Group:</b> <b>Network 1:</b> \$50 copay <b>Network 2:</b> \$75 copay <b>Network 3:</b> \$100 copay	\$20 copay per visit
<b>Ambulance</b>	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. Coinsurance does not count toward Calendar Year Out-of-Pocket Maximum.		Paid in full	After the Calendar Year Deductible, \$150 copay per trip
<b>PROFESSIONAL SERVICES</b>				
<b>Preventive Care</b>	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.	The plan pays 100%, not subject to copay or Calendar Year Deductible.	The plan pays 100%, not subject to copay or Calendar Year Deductible.
	Coverage is provided for the services, screenings, and exams listed in, and subject to the frequency described in, the Fund's Preventive Care Guidelines.			
<b>Physician Office Visits (Primary Care and Specialist)</b>	\$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.	<b>Network 1:</b> \$20 copay <b>Network 2:</b> \$35 copay <b>Network 3:</b> \$40 copay	\$20 copay per visit.

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<b>Surgeon, Assistant Surgeon, &amp; Anesthetist</b>	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	Covered under Hospitalization	After the Calendar Year Deductible, plan pays 80% of Covered Charges
<b>Outpatient X-ray and Laboratory</b>	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	Generally paid in full	Most x-rays and labs - \$10 per encounter after Deductible MRI, Most CT and Pet Scans \$50 per procedure after Deductible
<b>Speech Therapy Visits</b>	\$20 copay per visit, not subject to the Deductible. Limited to 24 visits per calendar year. Preauthorization required. Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity.	Not covered.	<b>Network 1:</b> \$20 copay <b>Network 2:</b> \$35 copay <b>Network 3:</b> \$40 copay	After the Calendar Year Deductible, \$20 copay per visit
<b>Physical Therapy Visits</b>	After Calendar Year Deductible, the Plan pays 80% of the Contract Rate. Pre-Authorization Required.  Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity. Benefit payment is limited to a maximum of 25 visits per calendar year.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount. Pre-Authorization Required.	<b>Network 1:</b> \$20 copay <b>Network 2:</b> \$35 copay <b>Network 3:</b> \$40 copay	After the Calendar Year Deductible, \$20 copay per visit
<b>Injections</b>	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.  Must be supplied and administered by Physician's office. Self-injectables are covered under Prescription Drug benefits.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	Office visit copay may apply	Office visit copay may apply.
<b>Chiropractic Care and Acupuncture</b>	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	Not covered

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PLATINUM PLAN SUMMARY As of January 1, 2012**

**MEDICAL BENEFITS**

	INDEMNITY PLAN		UNITED HEALTHCARE (UHC) FLEX HMO	KAISER
	PPO (In Network)	Non-PPO (Out of Network)		
<b>Podiatry</b>	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 for office visits. No benefits are paid for non-PPOC podiatrists.  Outside California, use the BlueCard network.	Not covered	After the Calendar Year Deductible, <b>Network 1:</b> \$20 copay <b>Network 2:</b> \$35 copay <b>Network 3:</b> \$40 copay	\$20 copay per visit.  Referral is required.
<b>Special Podiatry Benefit</b>	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.			
<b>Reconstructive Surgery Following Mastectomy</b>	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	After the Calendar Year Deductible, UHC pays: <b>Network 1:</b> 80% <b>Network 2:</b> 75% <b>Network 3:</b> 70%	After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges
	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.			
<b>Obesity Bypass Surgery</b>	Covered under the Hospital and Surgical benefits if Pre-Authorized as Medically Necessary.	Covered under Non-PPO Hospital and Non-PPO surgical benefits (including Non-PPO Outpatient Surgical Centers) if Pre-Authorized as Medically Necessary.	Covered if determined Medically Necessary and authorized.	

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**SOUTHERN CALIFORNIA DRUG BENEFIT FUND  
PLATINUM PLAN SUMMARY As of January 1, 2012**

**MEDICAL BENEFITS**

	INDEMNITY PLAN		UNITED HEALTHCARE (UHC) FLEX HMO	KAISER
	PPO (In Network)	Non-PPO (Out of Network)		
<b>Organ and Tissue Transplants</b>	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 copays, Coinsurance and coverage.	Must have referral to transplant facility. After Calendar Year Deductible, subject to plan Coinsurance and coverage.
<b>Vision Care – Pediatric (for Children up to age 18)</b>	Routine Eye exams are covered at 100% up to \$135 per exam. However, amounts paid for routine eye exams will reduce the annual frame and lens benefit.		Routine eye exams are subject to a Copay  If you go outside your HMO for routine pediatric eye exams, the Indemnity Plan will pay 100% up to \$135 per exam. However, amounts paid by the Indemnity Plan will reduce the \$135 annual frame and lens benefit.	Routine Eye Exams are covered through the HMO at 100% (no Deductible or Copay).  If you go outside your HMO for routine pediatric eye exams, the Indemnity Plan will pay 100% up to \$135 per exam. However, amounts paid by the Indemnity Plan will reduce the \$135 annual frame and lens benefit.
A \$135 maximum benefit for frames and lenses each calendar year.				
<b>Vision Care – Adults (age 18 and over)</b>	A \$135 maximum benefit for routine eye exams and/or frames and lenses each calendar year. For Kaiser and UHC, if eye exam is obtained through your HMO, the \$135 Indemnity Plan benefit can be used for frames and lenses). <b>For Kaiser Enrollees:</b> routine eye exams obtained through Kaiser are covered at 100% (not subject to Deductible or copay). <b>For UHC Enrollees:</b> routine eye exams through UHC are subject to copays.			
<b>Additional Accidental Injury Benefit</b>	In addition to other Plan benefits, a maximum of \$300 is payable for Contract Rates/Allowed Amounts for Medically Necessary services and supplies incurred within 90 days of an accident as a result of the accident.		Not applicable.	

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**SOUTHERN CALIFORNIA DRUG BENEFIT FUND  
PLATINUM PLAN SUMMARY As of January 1, 2012**

**MEDICAL BENEFITS**

	INDEMNITY PLAN		UNITED HEALTHCARE (UHC) FLEX HMO	KAISER
	PPO (In Network)	Non-PPO (Out of Network)		
<b>Home Health Care</b>	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. Coinsurance does not count toward Calendar Year Out-of-Pocket Maximum.		100% covered up to 100 visits per calendar year.	100% covered up to 100 visits per calendar year.
<b>MEDICAL SUPPLIES AND EQUIPMENT</b>				
<b>Outpatient Medical &amp; Surgical Supplies</b>	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.	After Deductible, Kaiser pays 80% of Covered Charges
<b>Orthopedic Appliances</b>	Reimbursement of 100% of Contract Rates or Allowed Amount for purchase or rental prescribed by a physician, up to once every calendar year.			
<b>Hearing Aids</b>	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.			
<b>Durable Medical Equipment</b>	The Plan pays 80% of Contract Rates.	The Plan pays 80% of the Allowed Amount.	Paid in full up to a \$5,000 maximum per calendar year.	Payable at 80% of Covered Charges (no Deductible). Durable medical equipment for home use is generally covered in accordance with Kaiser's durable medical equipment formulary guidelines.
	Coinsurance does not count toward the Out-of-Pocket Maximum.			

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## SOUTHERN CALIFORNIA DRUG BENEFIT FUND PLATINUM PLAN SUMMARY As of January 1, 2012

### PRESCRIPTION DRUG BENEFITS

<b>Participating Pharmacy</b>	All Participants must use Prescription Solutions' pharmacies. (See separate Directory at <a href="http://www.ufcdrugtrust.org">www.ufcdrugtrust.org</a> under "Downloads")
<b>Calendar Year Deductible</b>	None.
<b>Maximum Days Supply</b>	Maximum 30 days supply per prescription. For maintenance drugs in certain therapeutic classifications, a 90-day supply may be obtained.
<b>Generics</b>	\$8 copay per prescription.
<b>Formulary Brand</b>	\$25 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 \$25 copay.
<b>Non-formulary Brand</b>	\$45 copay per prescription.
<b>Injectables</b>	The Plan Pays 80% of Prescription Solutions' Contract Rate. Authorization required through Prescription Solutions.

### MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS

	INDEMNITY MEDICAL PLAN	UNITED HEALTHCARE	KAISER
<b>Mental Health</b> <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>Coverage is provided through the <b>Employee Member Assistance Program (EMAP)</b> administered by <b>Health Management Concepts (HMC)</b>.</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><b>Inpatient:</b> 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><b>Outpatient:</b> \$20 copay per visit, no Deductible. Maximum 50 visits per calendar year.</p>	<p><b>Inpatient:</b> \$500 copay per admission. For Non-AB 88 diagnoses, 30 days maximum per calendar year.</p> <p><b>Outpatient:</b> \$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><b>Inpatient psychiatric hospitalization and intensive psychiatric treatment programs;</b> You pay 20% of Covered Charges after Deductible.</p> <p><b>Outpatient mental health evaluation and treatment:</b> \$20 per visit (Deductible doesn't apply), \$10 per group visit (Deductible doesn't apply).</p>

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**SOUTHERN CALIFORNIA DRUG BENEFIT FUND  
PLATINUM PLAN SUMMARY As of January 1, 2012**

	INDEMNITY MEDICAL PLAN	UNITED HEALTHCARE	KAISER
<b>Chemical Dependency and Substance Abuse</b>	<p>Coverage is provided through the <b>Employee Member Assistance Program (EMAP)</b> administered by <b>Health Management Concepts (HMC)</b>.</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><b>Detoxification:</b> 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><b>Inpatient detoxification</b> - You pay 20% of Covered Charges after Deductible.</p>
	<p><b>Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program:</b> <u>Covered as mental health</u>; 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><b>Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program:</b> <u>Covered as mental health</u>; 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><b>Individual outpatient chemical dependency consultations and treatment</b> - \$20 per visit (Deductible doesn't apply).</p> <p><b>Group outpatient chemical dependency treatment</b> - \$5 per visit (Deductible doesn't apply).</p>

**DENTAL BENEFITS**

	INDEMNITY DENTAL PLAN	UNITED CONCORDIA
<b>Choice of Provider</b>	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.
<b>Covered Charges</b>	<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 <a href="http://www.ufcwdrugtrust.org">www.ufcwdrugtrust.org</a> under "Downloads").</p>	See United Concordia's Schedule of Benefits.
<b>Calendar Year Deductible</b>	\$75 per person; \$225 per family. Not applicable to routine preventative and diagnostic procedures.	None.
<b>Maximum Benefit</b>	\$1,800 per person per calendar year for adults age 18 and older.	No maximum.

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## SOUTHERN CALIFORNIA DRUG BENEFIT FUND PLATINUM PLAN SUMMARY As of January 1, 2012

### MEDICAL PLAN EXCLUSIONS

	INDEMNITY PLAN	KAISER & UNITEDHEALTHCARE
<b>Excluded Services</b>	<ul style="list-style-type: none"> <li>» Replacement of artificial eyes;</li> <li>» Orthognathic surgery;</li> <li>» Cosmetic treatment or surgery and complications resulting from any such procedure, except for repair of damage caused by accidental bodily injury (restorative surgery performed during or following mutilative surgery which was required as a result of illness or injury is not considered cosmetic);</li> <li>» Charges made by relatives of anyone in the Participant's household, except for Covered Charges which constitute out-of-pocket expenses to such providers;</li> <li>» Eye examinations including refractions and fitting of glasses, hearing aids, health aids, artificial limbs, and orthopedic appliances, except as specifically covered;</li> <li>» Custodial care regardless of the type of facility and/or provider;</li> <li>» Experimental treatment, procedures and therapies and any complications arising from such treatment;</li> <li>» 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;</li> <li>» 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;</li> <li>» Services and supplies for which no charge is made, or for which one is not required to pay;</li> <li>» 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;</li> <li>» Conditions covered by Workers' Compensation or incurred in the course of employment, including self-employment;</li> <li>» Penile prosthesis except when the cause of impotence is organic and then only if Pre-Authorized;</li> <li>» Pregnancy expenses of dependent children or expenses for conditions arising from pregnancy of dependent children;</li> <li>» Surgical correction of refractive problems including radial keratotomy unless vision cannot be corrected through eyeglasses or contact lenses;</li> <li>» 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;</li> </ul>	<p>Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare.</p>

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**SOUTHERN CALIFORNIA DRUG BENEFIT FUND  
PLATINUM PLAN SUMMARY As of January 1, 2012**

**MEDICAL PLAN EXCLUSIONS**

	<b>INDEMNITY PLAN</b>	<b>KAISER &amp; UNITEDHEALTHCARE</b>
	<ul style="list-style-type: none"> <li>» 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;</li> <li>» Benefits for treatment of nervous or mental disorders are limited to those provided under the EMAP;</li> <li>» Speech therapy, except from a PPO provider;</li> <li>» Take home drugs when discharged from the hospital;</li> <li>» Charges in excess of Contract Rates; or as applicable, the Allowed Amount;</li> <li>» Organ or tissue transplants performed at a facility that is not an Anthem Blue Cross Center of Expertise;</li> <li>» Expenses incurred by an organ or tissue donor when the transplant recipient is not a plan participant.</li> <li>» Expenses incurred by a transplant donor who is not eligible under the plan (except for benefits specifically provided);</li> <li>» Vocational testing, evaluation and counseling;</li> <li>» Injuries resulting from any form of warfare or invasion;</li> <li>» 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;</li> <li>» Claims filed more than one year after the date on which services were incurred;</li> <li>» Services or supplies that are not Necessary Treatment.</li> <li>» 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).</li> <li>» For Prescription Drug exclusions, please contact the Fund Office.</li> </ul>	
<b>Third Party Liability</b>	<ul style="list-style-type: none"> <li>» 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 Trust from such recovery in an amount not in excess of the payments made or to be made by the Trust.</li> </ul>	Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare

**DEATH BENEFITS**

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

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