SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY

As of January 1, 2012

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator by phone or in writing at So. Calif. Drug Benefit Fund, 2220 Hyperion Avenue, Los Angeles, CA 90027, (323) 666-8910. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans.

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY As of January 1, 2012

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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
Prescription Solutions	800-788-7871	www.rxsolutions.com
Delta Dental	800-765-6003	www.deltadentalins.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

This document is intended merely as a summary of the Platinum Plus 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 PLUS PLAN SUMMARY As of January 1, 2012

ELIGIBILITY RULES

ESTABLISHING ELIGIBILITY & COVERAGE COMMENCEMENT	
All Employees	If you work an average of 23 or more hours per week ("Qualifying Hours") in each of 3 consecutive months, you and your dependents will become eligible for all benefits, except orthodontic 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 and your dependents will be eligible for benefits, except Orthodontic, on June 1. Newly eligible participants, except for Kaiser Employees, are required to enroll in the Indemnity Medical Plan and will be eligible to enroll in an HMO plan on the 2nd annual open enrollment after their date of hire. Orthodontic coverage will be available to you and your dependents after you have 9 consecutive months of eligibility in the Platinum Plus Plan.
Coordination of Benefits Rule for Spouses	If you are married and enrolled in the Indemnity Medical Plan, and if your spouse's employer offers health care coverage, your spouse must 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.
Maintaining Eligibility	Once you become eligible, you must continue to work the Qualifying Hours during each month to maintain eligibility for yourself and your eligible dependents.

DEATH BENEFITS

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

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY As of January 1, 2012

MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	
How the Plan Works	For most office visits, you must pay a $10 copay per visit. Then the Plan pays 100% of Covered Charges. Effective January 1, 2009, when you use a PPO provider for preventive and wellness services, the Plan will pay 100% of Contract Rates[1] 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 copayment as long as services are received from PPO providers.	For most services, the Plan pays both Basic and Major Medical benefits. Basic Medical Benefits are paid first. After Basic Medical benefits have been exhausted, you must satisfy the required Calendar Year Deductible, then the Plan pays a percentage of the remaining Allowed Amount[2] as a Major Medical Benefit. For some services and supplies, specific dollar limits are imposed. You are responsible for any remaining balance after the allowed Basic and Major Medical benefits are paid.	Hospital and professional services are generally provided at no charge if received at HMO contracted facilities and provided by HMO providers. Refer to each benefit below for exceptions.
	Refer to each benefit below for exceptions.		
Preferred Provider Network (PPO)	If you live in California, your preferred provider network ("PPO") is the **Anthem Blue Cross Prudent Buyer** network. 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 **National BlueCard** network. The BlueCard network is available in all 50 states. 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. To find a PPO provider nearest you, call Anthem Blue Cross Prudent Buyer at 800-227-3641 or BlueCard Access at 800-810-BLUE.		You must use an HMO provider. Services rendered by non-HMO providers are not covered. If an emergency occurs outside of the HMOs' service areas, emergency procedures and benefits apply.

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

[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.

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY As of January 1, 2012

MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	
Calendar Year Deductible	None.	$50 per person per calendar year before Major Medical payments apply.	Not applicable.
Annual Dollar Limit (applies to Medical, Prescription Drug, Mental Health, and Substance Abuse benefits)	None for PPO (In Network)	$1,250,000 per person Major Medical for the 2012 calendar year.	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. **UnitedHealthcare**: See UnitedHealthcare's Evidence of Coverage.
HOSPITAL BENEFITS			
Hospital Inpatient Services (including Room and Board, and Ancillary Services)	100% of Contract Rates up to 120 days per disability, including ICU and childbirth. After 120 days, 80% of Contract Rates. Prudent Buyer/BlueCard providers are responsible for obtaining all Pre-Authorization and Utilization Review.	50% of the Allowed Amount up to 120 days per disability, including ICU only (excludes childbirth). After 120 days, 80% of the Allowed Amount. All hospital admissions, except for childbirth or emergency confinements, must be Pre-Authorized by Prudent Buyer/BlueCard. Call 800-274-7767 for Pre-Authorization. Benefits will be reduced if you fail to obtain required Pre-Authorization. Unauthorized days are not covered.	100% covered.
Physician Hospital Visits	100% of Contract Rates.	Basic Medical pays up to $25.50 per day. Major Medical pays 80% of the remaining Allowed Amount after Deductible.	100% covered.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY As of January 1, 2012

MEDICAL BENEFITS

<table>
<tr><th rowspan="2"></th><th colspan="2">INDEMNITY PLAN</th><th rowspan="2">KAISER & UNITEDHEALTHCARE</th></tr>
<tr><th>PPO (In Network)</th><th>Non-PPO (Out of Network)</th></tr>
<tr><td>Skilled Nursing Facility (Medicare approved)</td><td colspan="2">Maximum benefit of 42.5% of the semiprivate room rate of the previous hospital stay, for up to 2 times the unused number of allowed days per disability. The number of allowed days is 120 days minus the number of days spent in the hospital.

Patient must be transferred into the Skilled Nursing Facility within 14 days of acute care hospital stay lasting at least 3 days. Must be approved by Prudent Buyer/BlueCard.</td><td>As prescribed at designated facilities. 100% covered.

For Kaiser, limited to 100 days per benefit period.

For UnitedHealthcare, limited to 100 days per calendar year from the first treatment per disability.</td></tr>
<tr><td>Hospital Outpatient Facility Charges</td><td>100% of Contract Rates.</td><td>85% of the Allowed Amount.</td><td>100% covered.</td></tr>
<tr><td>Ambulance</td><td colspan="2">100% covered.</td><td>100% covered.</td></tr>
<tr><td>Hospital Emergency Room (Facility only, Physician charges are payable under Physician Hospital Visits)</td><td>100% of Contract Rates.</td><td>For accident, 85% of the Allowed Amount.
For illness, 68% of the Allowed Amount.</td><td>For Kaiser, 100% covered.

For UnitedHealthcare, $35 copay, waived if admitted as inpatient. Reasonable charges for emergency services received outside HMO service areas are covered, subject to Deductibles and copayments.</td></tr>
<tr><td rowspan="2">Outpatient Surgical Centers</td><td>100% of Contract Rates.</td><td>The Plan pays a maximum of $350 per surgery. You are responsible for any charges that exceed $350. Any charges in excess of the $350 do not count toward the Deductible.</td><td rowspan="2">100% covered.</td></tr>
<tr><td colspan="2">Must be Pre-authorized by Prudent Buyer/BlueCard.</td></tr>
</table>

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY As of January 1, 2012

MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	
PROFESSIONAL SERVICES			
Services of Surgeon, Assistant Surgeon	100% of Contract Rates.	Basic Medical benefits are paid according to a schedule of charges. Excess charges, after Basic Medical and Deductible, are covered under Major Medical at 80% of the Allowed Amount	100% covered.
Services by Anesthetist	100% of Contract Rates.	If provided in a hospital or outpatient surgical facility, 85% of the Allowed Amount. If provided in a physician's office, Basic Medical pays $21.25 per visit and no Major Medical is payable.	100% covered.
Preventive Care	Plan pays 100% of Contract Rates, no copayment is required.	After Calendar Year Deductible, Plan pays 85% of the Allowed Amount.	100% covered.
	Coverage is provided for the Preventive and Wellness services listed in, and subject to the frequency described in, the Drug Benefit Fund's Preventive Care Guidelines. .		
Physician Office Visits	$10 copay per visit.	Basic Medical pays up to $25.50 per visit up to a $300 maximum per calendar year. Benefits begin on the 1st visit for each accident and 2nd visit for each illness. After Basic Medical and Deductible have been satisfied, Major Medical pays 80% of the remaining Allowed Amount.	100% covered.
Specialist	$10 copay per visit.	Basic Medical pays up to $60 per visit for each accident and each illness when referred by attending physician. No Major Medical is payable.	100% covered.

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY As of January 1, 2012

MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	
Outpatient X-ray and Laboratory	100% of Contract Rates.	Basic Medical pays 85% of the Allowed Amount up to $750 maximum per accident or per calendar year for all illnesses. Major Medical pays 75% of the remaining Allowed Amount after Deductible.	100% covered.
Injections	100% of Contract Rates. Must be supplied and administered by Physician's office. Self-injectables are covered under Prescription Drug benefits.	Benefits for Injection are payable as an Office Visit and count toward Office Visit maximum.	Office visit copay may apply.
Physical Therapy	100% of Contract Rates. Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity.	Basic Medical pays up to $25.50 per visit, up to $300 maximum per calendar year. Major Medical pays 80% of the remaining Allowed Amount after Deductible.	100% covered.
Speech Therapy	$10 copay per visit. Preauthorization required. Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity.	Not covered.	100% 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.	100% covered if referred by your primary care physician to a podiatrist in your HMO.

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY As of January 1, 2012

MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	
Special Podiatry Benefit	A separate $120 calendar year benefit is available regardless of whether you are enrolled in an HMO Medical Plan 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	100% covered for 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.		
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. 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 - Pediatric **(for Children up to age 18)**	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.		Eye Exams are covered through the HMOs with a $25 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.		
Vision Care - Adults (age 18 and over)	A $135 maximum benefit for routine eye exams and/or frames and lenses each calendar year. For **Kaiser or UnitedHealthcare**, if eye exam is obtained through the HMO, the $135 Indemnity Plan benefit can be applied to frames and/or lenses.		

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY As of January 1, 2012

MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	
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.
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.		100% covered, up to 100 visits per calendar year.
MEDICAL SUPPLIES AND EQUIPMENT			
Outpatient Surgical Supplies	100% of Contract Rates.	Basic Medical pays up to $21.25 per visit for supplies, splints and dressings for surgery in a physician's office. No Major Medical is payable.	100% covered.
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.		

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY As of January 1, 2012

MEDICAL BENEFITS

	INDEMNITY PLAN		KAISER & UNITEDHEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	
Durable Medical Equipment	The Plan pays 80% of Contract Rates.	The Plan pays 80% of the Allowed Amount.	100% covered during a stay in a hospital or Skilled Nursing Facility. For **Kaiser**, Covered durable medical equipment for home use in accord with Kaiser's durable medical equipment formulary guidelines. For **UnitedHealthcare**, $5,000 maximum per calendar year.

PRESCRIPTION DRUG BENEFITS

	All Participants and Dependents (Except Kaiser Employees and their Dependents Enrolled in Kaiser)	Kaiser Employees and Their Dependents Enrolled in Kaiser
Participating Pharmacy	All Participants must use Prescription Solutions' pharmacies. (See separate Directory at www.ufcwdrugtrust.org under "Downloads")	Must use Kaiser pharmacies.
Maximum Days Supply	Maximum 30 days supply per prescription. For maintenance drugs in certain therapeutic classifications, a 90-day supply may be obtained.	Maximum 100 days supply per prescription.
Generics	$5 copay per prescription.	$5 copay per prescription.
Formulary Brand	$5 copay per prescription if no generic equivalent is available. $8 copay per prescription if a generic equivalent is available but 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 $8 copay.	$5 copay per prescription.
Injectables	The Plan pays 80% of Prescription Solutions' Contract Rate. Authorization required through Prescription Solutions.	

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY As of January 1, 2012

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS

<table>
<tr><th></th><th>INDEMNITY MEDICAL PLAN</th><th>UNITEDHEALTHCARE</th><th>KAISER</th></tr>
<tr><td rowspan="2">Mental Health

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.</td><td colspan="2">Coverage is provided through the Employee Member Assistance Program (EMAP) administered by Health Management Concepts (HMC).

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.</td><td rowspan="2">Coverage is provided through Kaiser. Participants must use Kaiser facilities and providers.

Inpatient: 100% covered. For Non-AB 88 diagnoses, maximum of 30 days per calendar year.

Outpatient: 100% covered. For Non-AB 88 diagnoses, 20 visits maximum per calendar year.</td></tr>
<tr><td>Inpatient: 100% covered, up to 70 days per calendar year.

Outpatient: For 1st to 5th visits, 100% covered. $10 copay per visit for 6th to 15th visits. $20 copay per visit for 16th to 50th visits. Maximum of 50 visits per calendar year.</td><td>Inpatient: 100% covered. For Non-AB 88 diagnoses, up to 30 days per calendar year.

Outpatient: 100% covered. For Non-AB 88 diagnoses, first 3 visits are 100% covered; $20 copay per visit for 4th to 20th visits; 20 visits maximum per calendar year.</td></tr>
<tr><td>Chemical Dependency and Substance Abuse</td><td colspan="2">Coverage is provided through the Employee Member Assistance Program (EMAP) administered by Health Management Concepts (HMC).

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.

Detoxification: The Plan pays 100% of HMC/APS Contract Rate.

Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program: <u>Covered as mental health;</u> 100% covered 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.</td><td>Coverage is provided through Kaiser. Participants must use Kaiser facilities and providers.

Inpatient Detoxification: 100% covered.

Transitional Residential Recovery Services: $100 copay per admission, up to 60 days per calendar year not to exceed 120 days in 5 calendar years.

Outpatient Therapy: 100% covered.</td></tr>
</table>

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY As of January 1, 2012

DENTAL BENEFITS

	INDEMNITY DENTAL 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.
Calendar Year Deductible	$50 per person; $150 per family. Not applicable to routine preventive and diagnostic procedures.	None.
Covered Charges	For DeltaPPO dentists, the Plan pays the lesser of the DeltaPPO Contracted Rates or the amount listed in the Schedule of Allowances. For DeltaPremier dentists, the Plan pays the lesser of the DeltaPremier filed fees or the amount listed in the Schedule of Allowances. 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. Schedule of Allowances is established by the Trustees and adjusted annually (see separate schedule at www.ufcwdrugtrust.org under "Downloads").	United Concordia's Schedule of Benefits.

ORTHODONTIC BENEFITS

	CONTRACTED ORTHODONTISTS	NON-CONTRACTED ORTHODONTISTS
Precertification Required	All treatment plans must be approved by the Plan's Orthodontic Consultant before treatment begins. If treatment begins before precertification, no benefits will be paid. Contact the Fund Office for more information.	
Full Treatment	The Plan allowance is $3,200. The Plan pays $3,000 of the contract rate after your copayment of $200.	Plan pays 80% of charges up to $3,000 maximum.
Limited Treatment	Plan pays 80% of the contract rate. You are responsible for the balance of the contract rate.	Plan pays 80% of charges up to $2,600 maximum.
Phase One Treatment	The Plan allowance is $1,250. The Plan pays $1,050 of the contract rate after your copayment of $200	Plan pays 75% of charges up to $2,500 maximum.
Development Supervision	The Plan allowance is $270. The Plan pays $220 after your copayment of $50.	Plan pays 80% of charges up to $270 maximum.
Lifetime Maximum Benefit	$3,000	

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SOUTHERN CALIFORNIA DRUG BENEFIT FUND

PLATINUM PLUS PLAN SUMMARY AS OF JANUARY 1, 2012

MEDICAL PLAN EXCLUSIONS

	INDEMNITY PLAN	KAISER & UNITEDHEALTHCARE
Excluded Services	» 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 (restorative surgery performed during or following mutilative surgery which was required as a result of illness or injury is not 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; » 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;	Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare.

MEDICAL PLAN EXCLUSIONS

	INDEMNITY PLAN	KAISER & UNITEDHEALTHCARE
Excluded Services (cont'd)	» 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; » 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; » Claims filed more than one year after the date on which services were incurred; » Serviced or supplies that are not Necessary Treatment;	Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare.

MEDICAL PLAN EXCLUSIONS

	INDEMNITY PLAN	KAISER & UNITEDHEALTHCARE
Excluded Services (cont'd)	» For Dental Exclusions, please refer to 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.	Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare.
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 Trust 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.