SOUTHERN CALIFORNIA DRUG BENEFIT FUND

SUMMARY OF THE RETIREE PLAN

AS OF JANUARY 1, 2012

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This document is intended merely as a summary of the Retiree health care plans 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 and UnitedHealthcare (formerly PacifiCare).

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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/hone.html
The BlueCard Program	800- 810-BLUE (800-810-2583)	www.bluecross.com
Prescription Solutions	800-788-7871	www.rxsolutions.com
Health Management Concepts, Inc.	866-268-2510	www.APSWorkLife.com [Login: SCDBF, Passcode: EMAP]
United Healthcare	800-624-8822	www.uhcwest.com
Podiatry Plan of California (PPOC)	800-367-7762	www.podiatryplan.com

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<table>
<tr><th rowspan="2"></th><th colspan="2">INDEMNITY PLAN</th><th rowspan="2">UHC FLEX HMO
Non-Medicare</th><th rowspan="2">KAISER
Non-Medicare</th><th rowspan="2">KAISER & UNITED HEALTHCARE
Medicare</th></tr>
<tr><th>PPO (In Network)</th><th>Non-PPO (Out of Network)</th></tr>
<tr><td>Preferred Provider Network</td><td colspan="2">If you live in California, your preferred provider network ("PPO") is <u>the California Anthem Blue Cross Prudent Buyer network</u>.

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.

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 doctor or hospital nearest you, call Anthem Blue Cross Prudent Buyer at 800-227-3641 or BlueCard Access at 800-810-BLUE.</td><td>With the UHC Flex HMO, there are three network choices. You must choose to participate in one of the three networks during open enrollment. You and all of your family members 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.

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 choose a PCP from the Signature Value Network. Your benefits will be the same as those provided under Network 1.

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.</td><td>You must use a Kaiser provider. Services rendered by non-Kaiser providers are not covered.

If an emergency occurs outside of the HMOs' service areas, emergency procedures and benefits apply.</td><td>You must use an HMO provider. Services rendered by non-HMO providers are not covered.

If an emergency occurs outside of HMO service areas, emergency procedures and benefits apply.</td></tr>
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	INDEMNITY PLAN		UHC FLEX HMO	KAISER	KAISER & UNITED HEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Non-Medicare	Medicare
How the Plan works	For visits to a PPO doctor, the Plan pays 100% of the contracted rate after you pay a $20 copay per visit. Before the Plan pays other benefits, you must satisfy the Calendar Year Deductible. The expenses you pay for using a PPO provider, except copayments for office visits and hospital stays, will apply toward the PPO deductible. The expenses you pay for using a non-PPO Provider, except for copayments for hospital stays and charges that exceed the Allowed Amounts[1], will apply toward the non-PPO deductible. After the required Calendar Year Deductible is satisfied, the Plan generally pays 80% of Contract Rates[2] if you use a PPO provider and 50% of the Allowed Amount if you use a non-PPO provider. For some services and supplies, specific dollar limits are imposed that result in the Fund paying less than these percentages. For hospital stays, you must first pay a $100 copayment per admission. When you use a PPO provider, you are responsible for the remaining 20% of Contract Rates. When you use a non-PPO provider, you are responsible for the remaining 50% of the Allowed Amount and for any charges that exceed the Allowed Amount. For PPO providers, once your out-of-pocket expenses have accumulated to the Calendar Year Out-Of-Pocket Maximum, the Plan will pay 100% of Contract Rates for the remainder of the Calendar Year. Your Calendar Year Deductible and copayments for PPO office visits and hospital stays do not count toward the Out-of-Pocket Maximum. There is no limit on out-of-pocket expenses when you use a non-PPO provider.		Generally, you must satisfy the Calendar Year Deductible before the plan 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. Preventive care services, such as your annual physical exams, are covered at 100% with no copay and not subject to the Deductible. For most other services, the plan pays a percentage of Covered Charges[3] depending on which network you choose. For example, if you choose Network 1, the plan will pay 80% and you will pay 20% of Covered Charges. 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.	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. 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. You must keep records (receipts) of your copayments and coinsurance as proof of payment.	For **Kaiser**, you pay a copay of $20 for each office visit and $500 for each inpatient hospital stay. For **UnitedHealthcare**, you pay a copay of $20 for each office visit and $500 for each inpatient hospital stay. Once you have paid the Calendar Year Copayment Maximum, all care will generally be covered in full. You must keep records (receipts) of your copayments as proof. The HMOs do not keep a record of your copayments.

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

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

[3] The amount that the UHC Provider has agreed by contract with UHC to accept for the services provided.

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	PPO (In Network)	**Non-PPO (Out of Network)**	**Non-Medicare**	**Non-Medicare**	**Medicare**
Coordination with Medicare	Members who are eligible for Medicare must enroll with Medicare. The Plan does not pay for the Part B premium. The Fund coordinates with Medicare. Under the Retiree Plan, Medicare typically pays first, and the Plan pays for the out-of-pocket expenses that you would incur under the original Medicare plan, such as the Part A and Part B deductibles, your coinsurance for hospitalization and skilled nursing, and the 20% Part B coinsurance. For services by a PPO facility in California, the Plan pays the lesser of (1) the Medicare deductibles/coinsurance or (2) the difference between the PPO contract rate and the Medicare payment. If a Medicare-eligible participant is covered under any other plan as an active employee or as a dependent of an active employee, that coverage would pay first, Medicare second, and the Trust Fund third. The Indemnity Plan does not pay for mental health, vision services, hearing aids, lab and x-rays related to physical exams, podiatry orthotics, orthopedic appliances, artificial limbs, and colostomy supplies because these services are not covered under the Fund (although they may be paid by Medicare).				Kaiser Senior Advantage and UnitedHealthcare Secure Horizons are Medicare Advantage with Prescription Drug Plans ("MA-PD Plans"). You must enroll with Medicare and assign your Part A, Part B, and Part D benefits to the MA-PD Plan. MA-PD Plans work like HMOs. You pay the applicable copayment for covered services.
Eligibility for Spouse and Dependents	If other coverage (non-Medicare) is available to one or more of your dependents (including your spouse), no coverage will be provided through this Plan for those dependents. Other coverage includes any coverage available through the dependent's employment or retirement, or that may be available to the dependent through any other employment or retirement, regardless of whether or not a premium is required for such coverage. It is your responsibility to notify the Trust Fund office when other coverage becomes available to your dependent(s). If your spouse or other dependents have any other health coverage (not including Medicare) available to them, they are not eligible for coverage under this Plan.				
Calendar Year Deductible	$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 Applies to many services, including most inpatient services and outpatient surgery. Does not apply to preventive care, most outpatient services, emergency services and 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 the Evidence of Coverage.	$500 per person, $1,000 per family Applies to most services except doctor's office visits and a few other services. See Kaiser's Evidence of Coverage for more information.	Not applicable.

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	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Non-Medicare	Medicare
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.	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 the plan'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.	**Copayment Maximums** are: For **Kaiser**, $1,500 per person, $3,000 per family. For **UnitedHealthcare**, $1,500 per person, $4,500 per family.
Covered Charges	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.	The amount that the HMO provider has agreed by contract to accept for the services.

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	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Non-Medicare	Medicare
Lifetime Maximum	$1,000,000 per person; $2,000,000 per family		Unlimited		
Plan Coinsurance	After you have satisfied the Calendar Year Deductible, the Plan pays 80% of Contract Rates for most services. Refer to each benefit below for exceptions. You are responsible for the balance.	After you have satisfied the Calendar Year Deductible, the Plan pays 50% of the Allowed Amount for most services. Refer to each benefit below for exceptions. You are responsible for the balance of the provider bill. Non-PPO providers often charge more than the Plan's Allowed Amount. When that happens, you are responsible for 50% of the Allowed Amount and 100% of any amount that exceeds the Allowed Amount.	Applies largely to Inpatient Hospitalization and outpatient surgery. After you satisfy the Deductible, UHC will pay: **Network 1:** 80% of Covered Charges **Network 2:** 75% of Covered Charges **Network 3:** 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[4] 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.	Not applicable

[4] The amount that the Kaiser Provider has agreed by contract with Kaiser to accept for the services provided.

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	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Non-Medicare	Medicare
HOSPITAL BENEFITS					
Hospital Inpatient Services (including Room and Board, and Ancillary Services)	After Calendar Year Deductible and $100 copay per admission, the Plan pays 80% of Contract Rates. Prudent Buyer/BlueCard providers are responsible for obtaining all Utilization Review. Copayment does not count toward Calendar Year Deductible or OOP maximum.	After Calendar Year Deductible and $100 copay per admission, the Plan pays 50% of the Allowed Amount. All hospital admissions, except for childbirth or emergency hospitalizations, must be pre-authorized by Prudent Buyer/BlueCard. Call 800-274-7767 for pre-authorization. Benefits will be reduced if you fail to obtain required Pre-Authorization Copayment does not count toward the Calendar Year Deductible.	After the Calendar Year Deductible, UHC pays: **Network 1:** 80% of Covered Charges **Network 2:** 75% of Covered Charges **Network 3:** 70% of Covered Charges	After Deductible, Kaiser pays 80% of Covered Charges	$500 copay per admission.

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<tr><th>PPO (In Network)</th><th>Non-PPO (Out of Network)</th></tr>
<tr><td rowspan="2">Skilled Nursing Facility (Medicare approved)</td><td>After Calendar Year Deductible, the Plan pays 80% of Contract Rates after $100 copay per admission, unless transferred directly from a hospital.
Copayment does not count toward Calendar Year Deductible or OOP maximum.</td><td>After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount after $100 copay per admission, unless transferred directly from a hospital.
Copayment does not count toward Calendar Year Deductible.</td><td rowspan="2">After the Calendar Year Deductible, UHC pays:
Network 1: 80% of Covered Charges
Network 2: 75% of Covered Charges
Network 3: 70% of Covered Charges
Limit of 100 consecutive days per Calendar Year from the first treatment per disability.</td><td rowspan="2">As prescribed at designated facilities. After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges. Limited to 100 days per benefit period.</td><td rowspan="2">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 colspan="2">Must be pre-authorized by Prudent Buyer/BlueCard. Limited to 240 days per disability. For Medicare members, the Plan covers the per-diem copayment for days 21 to 100. Check www.Medicare.gov for current copayment amount.</td></tr>
<tr><td>Ambulance</td><td colspan="2">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 towards the Calendar Year Out-of-Pocket maximum.</td><td>Paid in full</td><td>After the Calendar Year Deductible, $150 copay per trip.</td><td>100% covered if authorized.</td></tr>
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	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Non-Medicare	Medicare
Emergency Room (Facility, Physician and Ancillary Services)	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 patient has an "emergency medical condition", the Plan pays 80% of the Allowed Amount; otherwise 50% of the Allowed Amount after Deductible.	**Network 1:** $100 copay **Network 2:** $150 copay **Network 3:** $200 copay	After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges	$50 copay, waived if admitted as inpatient.
Urgent Care Visits (After-hour office visits)	$20 copay per visit, not subject to the deductible. Copayment does not count toward Calendar Year Deductible or OOP maximum.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	**Within Your Medical Group:** **Network 1:** $20 copay **Network 2:** $35 copay **Network 3:** $40 copay **Outside of Your Medical Group:** **Network 1:** $50 copay **Network 2:** $75 copay **Network 3:** $100 copay	$20 copay per visit	$20 copay.
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.	After the Calendar Year Deductible, UHC pays: **Network 1:** 80% of Covered Charges **Network 2:** 75% of Covered Charges **Network 3:** 70% of Covered Charges	After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges	For **Kaiser**, $20 copay per visit for Medicare Retirees For **UnitedHealthcare**, 100% covered.

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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. Charges in excess of this maximum do not count toward the Deductible or Out-of-Pocket Maximum.	After the Calendar Year Deductible, UHC pays: **Network 1:** 80% of Covered Charges **Network 2:** 75% of Covered Charges **Network 3:** 70% of Covered Charges	After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges	For **Kaiser**, $20 copay per visit for Medicare Retirees For **UnitedHealthcare**, 100% covered.
PROFESSIONAL SERVICES					
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.	After the Calendar Year Deductible, UHC pays: **Network 1:** 80% of Covered Charges **Network 2:** 75% of Covered Charges **Network 3:** 70% of Covered Charges	After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges	100% covered
Physician and Specialist Office Visits	$20 copay per visit, not subject to the Deductible. Copayment does not count toward Calendar Year Deductible or OOP Maximum.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	**Network 1:** $20 copay **Network 2:** $35 copay **Network 3:** $40 copay	$20 copay per visit.	$20 copay per visit.
Surgeon, Assistant Surgeon, & Anesthetist	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount.	Covered under Hospitalization	After the Calendar Year Deductible, plan pays 80% of Covered Charges	100% covered

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	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Non-Medicare	Medicare
Outpatient X-ray and Laboratory	After Calendar Year Deductible, the Plan pays 80% of Contract Rates. Not covered for physical exam purposes.	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	100% covered.
Injections	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	Office visit copay may apply.
Physical Therapy Visits	After Calendar Year Deductible, the Plan pays 80% of Contract Rates. Pre-Authorization Required. Benefit payment is limited to $2,500 per calendar year. Subject to Utilization Review by Prudent Buyer/BlueCard for Medical Necessity.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount. Pre-Authorization Required.	**Network 1:** $20 copay **Network 2:** $35 copay **Network 3:** $40 copay	After the Calendar Year Deductible, $20 copay per visit	$20 copay per visit.

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	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Non-Medicare	Medicare
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.	**Network 1:** $20 copay **Network 2:** $35 copay **Network 3:** $40 copay	After the Calendar Year Deductible, $20 copay per visit	$20 copay per visit
Chiropractic Care and Acupuncture	Plan pays $25.50 benefit per visit, one visit per day, up to a combined maximum of $500 per calendar year for office visits and $150 per calendar year for x-ray and laboratory. If not provided by a PPO provider, acupuncture is only covered when performed by a M.D.		Not covered	Not covered	For **Senior Advantage**, Not covered, except manual manipulations to correct subluxation, if covered by Medicare. For **Secure Horizons**, $20 copay, up to 12 visits maximum per calendar year.
Additional Accidental Injury Benefit	In addition to other Plan benefits, a maximum of $300 is payable for Contract Rates/Allowed Amounts of all Medically Necessary services and supplies incurred within 90 days of an accident as a result of the accident.		Not applicable.		

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	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Non-Medicare	Medicare
Reconstructive Surgery Following Mastectomy	After Calendar Year Deductible, the Plan pays 80% of Contract Rates.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount	After the Calendar Year Deductible, UHC pays: **Network 1:** 80% of Covered Charges **Network 2:** 75% of Covered Charges **Network 3:** 70% of Covered Charges	After the Calendar Year Deductible, Kaiser pays 80% of Covered Charges	$500 copay per admission
	Reconstruction of the breast on which a mastectomy is performed, surgery on the other breast to provide a symmetrical appearance, and prostheses and services in connection with physical complications of all stages of mastectomy, including lymphedemas.				
Organ and Tissue Transplants	Covered only if transplant is performed at an Anthem Blue Cross approved Center of Expertise, the transplant recipient is a plan participant, and the transplant is pre-authorized. Subject to Deductible and Plan Coinsurance. Under certain circumstances, donor search, organ or tissue procurement, and donor expenses are covered up to a combined lifetime maximum of $30,000.	Not covered	Must have referral to transplant facility. Subject to plan copays and/or coinsurance and coverage. Refer to your Evidence of Coverage for more information.	Must have referral to transplant facility. After Calendar Year Deductible, subject to plan coinsurance and coverage.	Must have referral to transplant facility. Subject to plan copayments and coverage.

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	INDEMNITY PLAN		UHC FLEX HMO	KAISER	KAISER & UNITED HEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Non-Medicare	Medicare
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	After the Calendar Year Deductible, **Network 1:** $20 copay **Network 2:** $35 copay **Network 3:** $40 copay	$20 copay per visit. Referral is required.	$20 copay per visit, if referred by your primary physician to a podiatrist
Home Health Care	Registered nurse expenses or licensed vocational nurse when prescribed by a physician as being Medically Necessary covered at 68%. Services and supplies provided in lieu of the services that would have been covered under the plan if confinement had been in a hospital or convalescent facility are covered. Homemaker services are not covered. Coinsurance does not count towards the Calendar Year Out-of-Pocket maximum.		100% covered up to 100 visits per calendar year.	100% covered up to 100 visits per calendar year.	100% covered

SOUTHERN CALIFORNIA DRUG BENEFIT FUND

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	INDEMNITY PLAN		UHC FLEX HMO	KAISER	KAISER & UNITED HEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Non-Medicare	Medicare
Vision Care	Not covered		**Network 1:** $20 copay **Network 2:** $35 copay **Network 3:** $40 copay	Routine Eye Exams are covered through the HMO at 100% (no Deductible or Copay).	$20 copay for eye examination. For Secure Horizons, no copay for one pair of Medicare-Covered eyeglasses or contact lenses after cataract surgery. For Senior Advantage, $150 allowance for material every 24 months when prescribed by a Plan Physician or Plan optometrist.
PREVENTIVE MEDICINE					
Physical Exam	For doctor's exam, $20 copay per visit, not subject to the Deductible. Copay does not count toward Calendar Year Deductible or Out-of-Pocket Maximum.	The Plan pays 50% of the Allowed Amount up to $60 maximum per calendar year for doctor's exam. Age and frequency limits apply	The plan pays 100%, not subject to Copay or Calendar Year Deductible.	Kaiser pays 100%, not subject to Copay or Calendar Year Deductible.	No copay.
	Outpatient x-ray and lab are not covered for physical exam purposes				

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	INDEMNITY PLAN		UHC FLEX HMO	KAISER	KAISER & UNITED HEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Non-Medicare	Medicare
Pap & Pelvic Exam	$20 copay per visit, not subject to the Deductible. Copay does not count toward Calendar Year Deductible or Out-of-Pocket Maximum.	After Deductible, the Plan pays 50% of the Allowed Amount	The plan pays 100%, not subject to Copay or Calendar Year Deductible.	Kaiser pays 100%, not subject to Copay or Calendar Year Deductible.	$20 copay per visit.
Well Child Care	$20 copay per visit, not subject to the Deductible. Copayment does not count toward Calendar Year Deductible or OOP maximum. For age 6 or under only.	After Deductible, the Plan pays 50% of the Allowed Amount up to $200 maximum per year until age 2, combined with immunization	The plan pays 100%, not subject to Copay or Calendar Year Deductible.	Kaiser pays 100%, not subject to Copay or Calendar Year Deductible.	No copayment for child under 2 years old
Immunization	After Calendar Year Deductible, the Plan pays 80% of Contract Rates. Must be for age 6 or under. If over age 6, only immunizations for school are covered.	After Calendar Year Deductible, the Plan pays 50% of the Allowed Amount, up to $200 maximum per year until age 2, combined with Well Child Care. If age 2 and over, only immunizations for school are covered.	The plan pays 100%, not subject to Copay or Calendar Year Deductible.	Kaiser pays 100%, not subject to Copay or Calendar Year Deductible.	$20 copay per visit
MEDICAL SUPPLIES AND EQUIPMENT					

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	INDEMNITY PLAN		UHC FLEX HMO	KAISER	KAISER & UNITED HEALTHCARE
	PPO (In Network)	Non-PPO (Out of Network)	Non-Medicare	Non-Medicare	Medicare
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.	After Deductible, Kaiser pays 80% of Covered Charges	100% covered
Durable Medical Equipment	The Plan pays 68% of Contract Rates.	The Plan pays 68% 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.	For **Kaiser Medicare Retirees**: Covered for home use in accordance with Kaiser's durable medical equipment formulary guidelines. For **UnitedHealthcare,** 100% covered during a stay in a hospital or Skilled Nursing Facility.

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MENTAL HEALTH BENEFITS

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.

	INDEMNITY MEDICAL PLAN	UNITEDHEALTHCARE	KAISER
Under Age 65	Not covered.	Provided through the **Employee Member Assistance Program** administered by **Health Management Concept, Inc. (HMC)**. All services and treatments must be pre-authorized by HMC and provided by APS network providers. No coverage for services and treatments by non-HMC approved providers.	Provided through **Kaiser**. Participants must use Kaiser facilities and providers.
Inpatient		$500 copay per admission. For non-AB 88 diagnoses, 30 days maximum per calendar year.	$500 copay per admission. For non-AB 88 diagnoses, 30 days maximum per calendar year.
Outpatient		$25 copay per visit. For non-AB 88 diagnoses, 20 visits maximum per calendar year.	$25 copay per visit ($12 copay for group visits). For non-AB 88 diagnoses, 20 visits maximum per calendar year.
Age 65 and Over	Not covered.	Provided through **UnitedHealthcare Secure Horizons**. Participants must use Secure Horizons contract facilities and providers.	Provided through **Kaiser Senior Advantage**. Participants must use Kaiser facilities and providers.
Inpatient		$500 copay per admission for the first 3 admissions in each calendar year, then 100% covered. Maximum 190 days per lifetime.	$500 copay per admission. For non-AB 88 diagnoses, Medicare provides up to 190 days per lifetime. After these days are exhausted, an additional 45 days per calendar year are covered through Kaiser.
Outpatient		$25 copay per consultation.	$25 copay per visit ($10 copay for group visits). For non-AB 88 diagnoses, 20 visits maximum per calendar year.

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CHEMICAL DEPENDENCY BENEFITS

<table>
<tr><th></th><th>INDEMNITY MEDICAL PLAN</th><th>UNITEDHEALTHCARE</th><th>KAISER</th></tr>
<tr><td rowspan="2">Under Age 65</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-authorized 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 Rates.</td><td rowspan="2">Coverage is provided through Kaiser. Participants must use Kaiser facilities and providers.
Inpatient Detoxification: $500 copay.
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: $25 copay per individual session, or $5 copay per group session.</td></tr>
<tr><td><u>Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program:</u> After the Deductible, Plan pays 80% of HMC/APS Contracted Rate after a $100 copay per admission for inpatient services. Plan covers 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.
<u>Outpatient</u>: Plan pays 100% after a $20 copay per visit.</td><td>Inpatient Rehabilitation, Day/Evening Hospital, and Intensive Outpatient Program: <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.</td></tr>
<tr><td>Age 65 and Over</td><td>Covered as above for Under Age 65.
Coordination with Medicare applies. .</td><td>Provided through UnitedHealthcare Secure Horizons. Participants must use Secure Horizons contract facilities and providers.
Inpatient Detoxification: $500 copay per admission for the first 3 admissions in each calendar year.
Outpatient Therapy: $25 copay per visit.</td><td>Provided through Kaiser. Participants must use Senior Advantage contract facilities and providers.
Inpatient Detoxification: $500 copay.
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: $20 copay per individual session, or $5 copay per group session.</td></tr>
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PRESCRIPTION DRUG BENEFITS

	INDEMNITY PLAN	UNITEDHEALTHCARE & KAISER
	Non-Medicare Retirees and Medicare-eligible Retirees not enrolled in a Senior Advantage Plan	**Medicare Retirees enrolled in a Senior Advantage Plan**
Participating Pharmacy	All Participants must use Prescription Solutions' pharmacies.	Participants must use the HMO's pharmacies.
Calendar Year Deductible	$50 per person.	None.
Maximum Days Supply	Maximum 30 days supply per prescription. For maintenance drugs in certain therapeutic classifications, a 90-day supply may be obtained.	Maximum 30 days supply per prescription. For a maintenance drug, a 100-day supply for Kaiser or a 90-day supply for UnitedHealthcare may be obtained with two copays through mail order.
Generics	After deductible, $12 copay per prescription.	For **Senior Advantage,** $10 copay per prescription. For **Secure Horizons,** $15 copay per prescription.
Formulary Brand	After deductible, $30 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 $30 copay.	$25 copay per prescription.
Non-formulary Brand	After deductible, $50 copay per prescription.	For **Senior Advantage**, not covered. For **Secure Horizons,** $40 copay per prescription.
Injectables	After deductible, the Plan pays 80% of Prescription Solutions' Contract Rate. Authorization required through Prescription Solutions.	Certain injectables are covered.
Maximum Benefit	$25,000 per person per calendar year.	No maximum.
Medicare Part D (Medicare eligible retirees only)	If you or your spouse enroll in an individual Medicare Part D plan, you will lose prescription drug coverage under the Retiree Health Plan.	If you or your spouse enroll in an individual Medicare Part D plan, the HMO will terminate your coverage and you and your eligible dependents will be transferred into the Indemnity Medical Plan provided by the Retiree Health Plan. Under the Indemnity Medical Plan, Prescription drug coverage will not be available for retirees and/or dependents who have enrolled in an individual Medicare Part D Plan.

MEDICAL PLAN EXCLUSIONS

	INDEMNITY PLAN	KAISER & UNITEDHEALTHCARE
Excluded Services	» Replacement of artificial eyes; » Orthognathic surgery; » Dental Care and dental x-rays, except for dental tumors; » Orthodontic care; » Cosmetic treatment or surgery and complications resulting from any such procedure, except for repair of damage caused by accidental bodily injury while eligible under the plan (restorative surgery performed during or following mutilative surgery which was required as a result of illness or injury shall not be considered cosmetic); » Charges made by relatives of anyone in the Participant's household, except for covered charges which constitute out-of-pocket expenses to such providers; » Eye examinations including refractions and fitting of glasses, hearing aids, health aids, artificial limbs, and orthopedic appliances, except as specifically covered; » Custodial care regardless of the type of facility and/or provider; » Experimental treatment, procedures and therapies and any complications arising from such treatment; » Any supplies or services furnished by a hospital or facility operated by the U.S. Government or any authorized agency thereof, or furnished at the expense of such Government or agency; » Any expenses connected with any form of artificial insemination, any non-surgical treatment for infertility after diagnosis, any expenses connected with or resulting from surrogate mothers or sperm banks, or the reversal of voluntary infertility; » Services and supplies for which no charge is made, or for which one is not required to pay; » Any services or supplies not recommended and approved by a legally qualified physician or surgeon, dentist, mental health professional, podiatrist on the PPOC panel, or chiropractor performing services within the legal scope of their practices; » Conditions covered by Workers' Compensation or incurred in the course of employment, including self-employment; » Speech therapy, except from a PPO provider;	Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare.

MEDICAL PLAN EXCLUSIONS

	INDEMNITY PLAN	KAISER & UNITEDHEALTHCARE
Excluded Services (cont'd)	» Penile prosthesis except when the cause of impotence is organic and then only if Pre-Authorized; » Pregnancy expenses of dependent children or expenses for conditions arising from pregnancy of dependent children; » Surgical correction of refractive problems including radial keratotomy unless vision cannot be corrected through eyeglasses or contact lenses; » Any treatment or procedure designed to alter physical characteristics of the covered individual to those of the opposite sex and any other treatment or studies related to sex transformations, sex change counseling, treatment or surgery; » Expenses incurred for any condition where there exists no injury or sickness, except that this exclusion does not apply to benefits specifically provided, such as hospice care, sterilization procedures, and preventive care benefits; » Treatment of nervous or mental disorders; » Take home drugs when discharged from the hospital; » Charges in excess of Contract Rates; or as applicable, the Allowed Amount; » Organ or tissue transplants performed at a facility that is not an Anthem Blue Cross Center of Expertise; » Expenses incurred by an organ or tissue donor when the transplant recipient is not a plan participant. » Expenses incurred by a transplant donor who is not eligible under the plan (except for benefits specifically provided); » Vocational testing, evaluation and counseling; » Injuries resulting from any form of warfare or invasion; » No benefits will be provided for podiatric care received from a non-PPOC podiatrist (if you live outside of California no podiatry benefits will be provided unless you use a BlueCard network podiatrist). In addition, benefits for podiatric care are limited to those specifically described; » Hearing aids, artificial limbs, orthotics, orthopedic appliances, and colostomy supplies; » Lab and x-rays related to physical exams;	Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare.

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MEDICAL PLAN EXCLUSIONS

<table>
<tr><th></th><th>INDEMNITY PLAN</th><th>KAISER & UNITEDHEALTHCARE</th></tr>
<tr><td>Excluded Services (cont'd)</td><td>» Claims filed more than one year after the date on which services were incurred;
» Services or supplies that are not Necessary Treatment.
» For Prescription Drug exclusions, please contact the Fund Office.</td><td>Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare.</td></tr>
<tr><td>Amendment of Plan</td><td colspan="2">All terms of the Retiree Health Plan are subject to amendment by the Board of Trustees or by the Unions and Retail Drug Employers. Benefits under the prepaid medical programs (HMOs) are also subject to amendments by the Trustees, the Unions and Employers, and the HMOs themselves. Benefits under the Plan are not vested. The continuation of retiree benefits depends on the continuation of Collective Bargaining Agreements which require Employers to make contributions for these benefits.

Benefits will be continued to the extent that the Employer contributions provide for financing of these benefits. If contributions become insufficient to pay for all Plan benefits, benefits may be reduced or eliminated or the eligibility rules may be changed. Future Collective Bargaining Agreements may terminate the Plan.</td></tr>
<tr><td>Third Party Liability</td><td>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.</td><td>Please refer to the Evidence of Coverage booklets provided by Kaiser and UnitedHealthcare</td></tr>
</table>