Southern California Dairy Industry Security Fund

Hospital and Medical
Benefit Options For

Retirees
Plan 2

This is a Summary only. Each option has additional benefits; limitations and exclusions. Additional details are available in the appropriate Plan Document. THE FINAL AUTHORITY IS THE ACTUAL PLAN DOCUMENT.

Effective April 1, 2012

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SWA Group Number 106
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BENEFITS	FEE FOR SERVICE PLAN RETIREE
HOSPITAL BENEFITS 1. Room and Board including general nursing care, meals and special diets.	Retiree and Spouse - covered at 100% when hospitalized at a **Preferred Provider** (PPO) facility. 60% for a non-PPO facility. Pre-admission approval is required by First Health or your benefits will be reduced by 50%. Call 1-800-559-8723.
2. Extras: operating rooms; special treatment rooms; surgical dressings; splints and plaster casts.	Retiree and Spouse - Included as part of #1 above.
3. X-ray examinations; laboratory tests, and physical therapy.	Retiree and Spouse - Included as part of #1 above.
4. Drugs, medicines and injections.	Retiree and Spouse - Included as part of #1 above.
5. Anesthetist.	80% of allowable charges.
6. Ambulance Service.	80% of allowable charges for trips to and from local hospitals, when medically necessary.
EXTENDED CARE / SKILLED NURSING	Provided for treatment of the totally disabling illness or injury only. See SPD for other applicable limitations.
SURGICAL	80% of allowance for a **Preferred Provider**. 60% of usual, reasonable and customary **Non-Preferred Provider.**
MATERNITY	Employee and Spouse — Normal plan benefits.
DIAGNOSTIC X-RAY AND LABORATORY BENEFITS 1. Hospital inpatient.	Covered under hospital extras #2 above.
2. Hospital outpatient laboratory or doctor's office.	80% for a Preferred Provider, 60% non-PPO.
DOCTOR'S VISITS 1. In Hospital	80% of allowance for a **Preferred Provider** physician. 60% non PPO.
2. In Office	80% of allowance for a **Preferred Provider** Physician. 60% non PPO. Wellness benefits available. See Plan booklet.
3. At Home	80% of allowance for a **Preferred Provider** Physician. 60% non PPO.
MENTAL HEALTH SERVICES	The Teamsters Referral Program provided by APS (APS) Healthcare provides pre-admission review, case management and quality assurance review of all outpatient care and hospitalization. APS must be contacted prior to receiving treatment or benefits. **Call APS at 1-800-431-5036 for pre-authorization.**
ALCOHOLISM AND SUBSTANCE ABUSE BENEFITS	The Teamsters Referral Program provided by APS (APS) Healthcare provides pre-admission review, case management and quality assurance review of all outpatient care and hospitalization. APS must be contacted prior to receiving treatment or benefits. **Call APS at 1-800-431-5036 for pre-authorization.**
MAJOR MEDICAL	$750,000 Annual Maximum benefit for Essential Health Benefits. Allowable expenses limited to Usual, Customary and Reasonable amounts. Mental health & substance abuse lifetime maximums not included. $100 deductible per individual. Maximum family deductible of $300.00 per calendar year.
PRESCRIPTION DRUGS/Medco Health (Retirees enrolled in an HMO must use the HMO prescription drug plan)	**Retail** (30 day supply): $5.00 Generic/$10.00 Brand/$25.00 non-prefered. **Mail Order** (90 day supply): $10.00 Generic/$20.00 Brand/$35.00 non-preferred. **Mandatory Mail order after 2nd refill.**
CHOICE OF DOCTOR **CHOICE OF HOSPITAL**	Preferred Provider hospitals and physicians. Benefits are reduced if a non-Preferred Provider is utilized.
OUT OF AREA / EMERGENCY SERVICES	Normal Plan Benefits provided. No area restrictions. There will be no reduction of benefits to 60% when a contracting hospital or physician is not within 20 miles of the member's residence or if the contracting hospital or physicians in your area cannot provide the services or treatment medically necessary.
ANNUAL CO-PAYMENT MAXIMUM	$1,000 out-of-pocket maximum per individual per calendar year.
ELIGIBLE DEPENDENTS	(a) Retiree's spouse
EXCLUSIONS AND LIMITATIONS (Coordination of Benefits — All plans)	Comprehensive Medical Expense Benefits are not payable for expenses incurred in connection with: 1. reconstruction of prior surgical sterilization procedures; 2. hearing aids 3. any procedure or treatment designed to alter the physical characteristics of the individual to those of the opposite sex; 4. professional services received from a physician, registered nurse or physical therapist who lives in your home or who is related to you by blood or marriage; 5. inpatient hospital charge in connection with a hospital stay primarily for physical therapy; 6. cosmetic surgery or other services for beautification, except to correct functional disorders or as a result of accidental injury which occurs while you or your spouse are covered under this Plan; 7. orthopedic shoes (except when joined to braces) or shoe inserts, air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification, educational services, nutritional counseling or food supplements; 8. routine physical examinations, see Wellness Benefits. 9. care or treatment of obesity or weight reduction, including medical, surgical or psychiatric care; 10. any operation or treatment in connection with the fitting or wearing of dentures, or for treatment of the teeth and gums, except for tumors and services of a physician or dentist treating an accidental injury to natural teeth which occurs while you or your spouse are eligible under the Plan, if such services are received during the six months following the date of injury 11. care and treatment that is not according to accepted professional standards; 12. services or supplies for the removal of corns or calluses, or trimming of toenails, treatment of chronic conditions of the foot such as weak or fallen arches, flat or pronated matalorsalgia, or foot strain; 13. inpatient admissions primarily for diagnostic studies when inpatient bed care is not medically necessary; 14. custodial care or rest cures, services provided by a rest home, a home for the aged, a nursing home or any similar facility; 15. optometric services, eye exercises including orthoptics, routing eye exams and routine eye refractions, eyeglasses or contact lenses; and 16. inpatient hospital care in connection with the confinement of a terminally ill patient in excess of three weeks, unless prior approval has been obtained from the Fund Office and in no circumstances will such benefits exceed a maximum of six consecutive months.

UNITED HEALTHCARE	KAISER
Retiree and Spouse - Provided without charge.	Retiree and Spouse — If you are not Medicare eligible, you are eligible to enroll for Kaiser benefits.
Retiree and Spouse - Provided without charge.	Retiree and Spouse — Provided without charge.
7Retiree and Spouse - Provided without charge.	Retiree and Spouse — Provided without charge.
Retiree and Spouse - Provided without charge.	Retiree and Spouse — Provided without charge.
Retiree and Spouse - Provided without charge.	Retiree and Spouse — Provided without charge.
Retiree and Spouse - Provided without charge when determined medically necessary and approved by a Pacificare Plan physician.	Retiree and Spouse — Covered in full when determined medically necessary and approved by a Kaiser Plan physician.
Covered up to 100 days per benefit period as defined by Medicare.	Retiree and Spouse — Provided without charge, for 100 days per calendar year.
Retiree and Spouse - Provided without charge.	Retiree and Spouse — Provided without charge.
Retiree and Spouse - Provided without charge.	Retiree and Spouse — Normal delivery, Cesarean Section covered in full. Prenatal and Postnatal, $5.00 charge per visit. No charge for x-ray, lab or other tests. Hospitalizations – No Charge.
Retiree and Spouse - Included in Hospital Benefits.	Retiree and Spouse — Included in Hospital Benefits.
Retiree and Spouse - Provided without charge.	Retiree and Spouse — Provided without charge.
Retiree and Spouse - Provided without charge. Out-of-area urgent care $50.00.	Retiree and Spouse — Provided without charge.
Retiree and Spouse - $10.00 co-payment per visit.. **SECURE HORIZONS** - $5.00 co-payment per visit.	There is a $10.00 co-payment per visit. Specialist/Consultant visits are a $10.00 co-payment per visit.
There is no charge for services that are a part of a prescribed home health care program.	There is no charge for services within the Kaiser Service Area that are a part of a prescribed home care program.
The Teamsters Referral Program provided by APS (APS) Healthcare provides pre-admission review, case management and quality assurance review of all outpatient care and hospitalization. APS must be contacted prior to receiving treatment or benefits. **Call APS at 1-800-431-5036 for pre-authorization.**	All Mental Health Services must be provided by Kaiser Permanente. Outpatient visits: Up to a total of 20 individual and/or group therapy visits per calendar year. Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year. $10.00 co-payment per visit. Note: Visit or day limits do not apply to severe mental illnesses and serious emotional disturbances of children as described in the Evidence of Coverage.
The Teamsters Referral Program provided by APS (APS) Healthcare provides pre-admission review, case management and quality assurance review of all outpatient care and hospitalization. APS must be contacted prior to receiving treatment or benefits. **Call APS at 1-800-431-5036 for pre-authorization.**	Inpatient detoxification at no charge, outpatient individual therapy visits $10.00 per visit, Outpatient group therapy visits $5.00 per visit, Transitional residential recovery services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)
Does not apply. Covered benefit as outlined.	Does not apply. Covered benefit as outlined.
Non-Medicare members $5.00 Generic $10.00 Brand Mail order 2 co-payments for 90 day supply per prescription at a PacifiCare participating pharmacy. Medicare members $7.00 Generic $14.00 Brand. Mail order 2 co-payments for 90 day supply per prescription at a PacifiCare participating pharmacy.	$10.00 co-pay per prescription, up to a 100-day supply at a Kaiser pharmacy.
Services provided by Pacificare contracted Independent Practice Associations (IPAs) and Medical Groups.	Services provided by Kaiser physicians and Kaiser hospitals.
EMERGENCIES ONLY:WITHIN SERVICE AREA: $50.00 charge; waived if admitted directly from the hospital emergency room. See Pacificare Plan document for details. OUTSIDE SERVICE AREA: $50.00 charge; waived if admitted directly from the hospital emergency room. Continuing or follow-up care covered only if provided or authorized by participating medical group or IPA. You must notify your participating medical group or IPA within 48 hours after an emergency occurs. Benefits payable on a life threatening condition. See Pacificare evidence of coverage.	EMERGENCIES ONLY: WITHIN SERVICE AREA/KAISER FACILITIES: $50.00 co-pay if not hospitalized. OUTSIDE THE SERVICE AREA/NON-KAISER FACILITIES: $50.00 co-pay if not hospitalized. Follow-up care to be received and/or directed by a Kaiser physician. It is recommended to call Kaiser within 48 hours and to submit a statement of emergency with your claim. EMERGENCIES ONLY:
Annual co-payment maximum of $2,000.00 per member, $6,000.00 maximum per family. Medicare members $6,700.	Annual co-payment maximum of $1,500.00 per person. Limited to $3,000.00 per family limit.
(a) Retiree's spouse	(a) Retiree's spouse.
All services and benefits for care and conditions within each of the following classifications shall be excluded from coverage under this plan, except such services as may be specifically provided. 1. All services not specifically included in this brochure; all non-emergency services rendered without authorization from your participating medical group, or the medical group's utilization review committee, services prior to your start date of coverage or subsequent to the time coverage ends. 2. **Alcoholism, drug addiction, other substance abuse.** Rehabilitation for chronic alcoholism, drug addiction or other substance abuse, except as provided as a supplemental benefit. 3. **Ambulance service.** Ambulance services unless medically necessary and authorized by your family doctor or necessitated by an emergency. 4. **Artificial insemination.** Except when medically indicated. 5. **Cosmetic surgery.** Except when medically necessary. 6. **Custodial or domiciliary care.** 7. **Dental care, dental appliances.** 8. **Disabilities connected to military services.** Treatment for disabilities connected to military services for which you are legally entitled, and to which you have reasonable accessibility (i.e., services through a federal governmental agency.) 9. **Donor services.** Medical and hospital services of a donor or prospective donor when the recipient of an organ transplant is not a member. 10. **Drugs and medication prescription.** Prescribed and non-prescribed drugs and medicines for outpatient care, except as provided as a supplemental benefit. (Serum used in the treatment of allergies is not covered.) 11. **Experimental or investigative procedures.** Experimental medicine, surgery, or other experimental health care procedures unless approved as a basic health care service by PacifiCare. 12. **Fertility procedures.** Not covered. 13. **Hearing aids.** 14. **Non-eligible institutional services and supplies.** Any services or supplies furnished by a non-eligible institution (defined as other than a legally-operated hospital or Medicare-approved skilled nursing facility, or which is primarily a place of rest, a place for the aged, a nursing home or any similar institution, regardless of how denominated. 15. **Mental or nervous disorders.** All inpatient mental health services and outpatient mental health services in excess of 20 visits per year, except as provided as a supplemental benefit. 16. **Non licensed professionals.** Treatment for any illness or injury when not attended by a licensed physician or surgeon or health care professional. 17. **Private duty nursing.** Unless determined to be medically necessary and ordered by your family doctor. 18. **Physical examinations.** Routine physical examinations for insurance, licensing, employment, school, camp, or other nonpreventive purposes or for premarital and pre-adoption purposes 19. **Private rooms and comfort items.** Personal or comfort items and private rooms unless medically necessary during inpatient hospitalization. 20. **Public facility care.** Care of conditions for which state or local law requires treatment in a public facility, however, PacifiCare will reimburse you for out-of-pocket expenses incurred for any covered benefits delivered at such public facility. 21. **Long-term care.** Rehabilitative services including physical, occupational, and speech therapy over 60 consecutive calendar days from the first date of treatment per disability. 22. **Sex transformations.** Transsexual surgery. 23. **Treatment refusal.** Charges for services when you have refused recommended treatment for personal reasons, when your family doctor believes no professional-acceptable alternative treatment exists. 24. **Vision care.** Corrective lenses and frames, contact lenses (except post-cataract extraction), except as provided as a supplemental benefit.	The following are excluded from your Kaiser Permanente coverage. 1. Financial responsibility for conditions covered by Workers' Compensation 2. Financial responsibility and services for care that is required to be provided only by a governmental agency 3. Financial responsibility for services that an employer is required by law to provide. 4. Services for military service connected conditions, as defined by the Veterans Administration, for which case is reasonably available to the member from the Veterans Administration 5. Physical examinations and related services required for insurance, employment, of licensing or ordered by the court 6. Dental care and dental X-rays, including accidental injury to teeth; dental appliances; orthodontia; and dental services associated with surgery on the jawbone 7. Services related to conception by artificial means (except artificial insemination) such as in vitro fertilization and ovum transplant; the cost of donor semen 8. Services to reverse voluntary, surgically induced infertility 9. Chiropractic services and services of a chiropractor 10. Routine non-medically necessary foot care services 11. Experimental or investigational services (see "Definitions," page 27) and those procedures not generally and customarily provided to patients residing in the Service Area 12. Cosmetic services, (i.e., services that are performed primarily to improve appearance) 13. Non-human and artificial organs and their implantation 14. Services related to sexual reassignment surgery 15. Durable medical equipment, except as otherwise specifically included for other members. 16. Drugs and medications when used for cosmetic purposes 17. Custodial care, or care in an intermediate care facility. **Limitations** 1. In the event of one of the following: major disaster; epidemic; war; riot; civil insurrection; disability of significant part of hospital or Medical Group personnel complete or partial destruction of facilities or other circumstances beyond Kaiser Permanente's control, Kaiser Permanente will make a good faith effort to provide - or arrange for covered services. However, it will not be responsible for any delay or failure in providing benefits or services due to lack of available facilities or personnel. 2. Coverage is not provided for care for conditions for which a member has refused recommended treatment for personal reasons when Medical Group physicians believe no professionally acceptable alternative treatment exists. 3. Physical, occupational, and speech therapies are limited to conditions (including acute phases of chronic conditions) subject to significant improvement in function within a two-month period. Inpatient and outpatient rehabilitation including these therapies is limited to a two-month period per condition. 4. Coverage for orthotics, prosthetics, and other corrective appliances and artificial aids, except as otherwise specifically included, is limited to the following: permanent internally implanted devices such as pacemakers and hip joints; a prosthesis, including one that is custom-made if required; and necessary replacements following a medically indicated mastectomy and prosthetic devices and installation accessories (but not electronic voice producing machines) to restore a method of speaking following a laryngectomy. 5. Coverage is not provided for mental health services for the care of chronic psychosis, organic psychosis, and other conditions that a Plan physician considers would not be responsive to therapeutic management; care for mental retardation; care as a condition of parole or probation, unless determined by a Plan physician to be necessary and appropriate; court-ordered testing; testing for intelligence, aptitude, or interest. 6. Coverage is not provided for alcohol and drug dependency services as follows: continuation of counseling for disruptive or physically abusive patients, and methadone maintenance. 7. Coverage is provided for internally implanted time-release medications, except as otherwise specifically included.