Southern California Dairy Industry Security Fund
Fee-For Service

Coverage Period: 12/01/2014 – 11/30/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual & Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the summary plan description or plan document at www.scdairyfund.org or by calling 1-866-481-5841. A copy of the Uniform Glossary can be accessed at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$100** person **/$300** family. Amounts used to satisfy the deductible in last quarter can also be used to satisfy next year's deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for their costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. Medical: **$1,000** per person / $8,000 per family. Prescription: **$1,300** per person / $4,000 per family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges (including balance billing for the Fund's mandatory generic program), deductibles, penalties for failure to pre-certify and, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. Visit www.bluecrossca.com to view	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the terms in-network, **preferred,** or

	the list of PPO providers or you may contact the Fund Office at (562)463-5033 or (866)481-5841 and request a directory.	participating **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your summary plan description or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network PPO **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% of allowed amount + balance	After deductible
	Specialist visit	20% coinsurance	40% of allowed amount + balance	After deductible
	Other practitioner office visit	20% coinsurance	40% of allowed amount + balance 20% coinsurance for chiropractic care.	After deductible. Chiropractic care for PPO and Non-PPO providers is limited to 20 visits per year.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	No charge	Not covered	Non-preventative physical exams for employees, spouses/domestic partners are allowed up to $500 per visit.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% of allowed amount + balance	After deductible. X-rays ordered by a chiropractor limited to one set per year.
	Imaging (CT/PET scans, MRIs)	20% coinsurance. No charge for preventive imaging.	40% of allowed amount + balance	After deductible for non-preventive care.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com. Or call (800) 228-3108	Generic drugs	$5.75 copay per prescription for Retail; $11.50 copay for Mail Order	If you live more than 15 miles from a network pharmacy, the Fund will reimburse 75% of the cost.	Maximum day supply – 30-day retail; 90-day mail. Mail order mandatory for maintenance medications. Preferred & non-preferred brand drugs are only covered when a generic is not available or with letter of medical necessity from your physician. If brand is requested without physician request, copay will be difference between cost of brand and generic medication. Out-of-network coinsurance applies if you live15 or more miles from a Sav-Rx pharmacy.
	Preferred brand drugs	$11.50 copay per prescription for Retail; $23.00 copay for Mail Order		
	Non-preferred brand drugs	$28.75 copay per prescription for Retail; $40.25 copay for Mail Order		
	Specialty drugs	Same copays apply (Generic, Preferred brand or Non-preferred Brand)		Prior authorization required – 30-day supply

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% of allowed amount + balance	After deductible. For non-PPO, 20% coinsurance if you live more than 20 miles from PPO provider.
	Physician/surgeon fees	20% coinsurance	40% of allowed amount + balance	After deductible.
If you need immediate medical attention	Emergency room services	20% coinsurance	20% of allowed amount + balance	After deductible.
	Emergency medical transportation	20% coinsurance	20% of allowed amount + balance	After deductible
	Urgent care	20% coinsurance	40% of allowed amount + balance	After deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% of allowed amount + balance	After deductible. Inpatient certification required by Anthem Blue Cross, otherwise benefit payments will be reduced by 50%. For non-PPO, 20% coinsurance if you live more than 20 miles from PPO provider.
	Physician/surgeon fee	20% coinsurance	40% of allowed amount + balance	After deductible

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs. For help, contact HMC Healthworks at 1-800-431-5036.	Mental/Behavioral health outpatient services	No charge	40% of allowed amount + balance	Not subject to deductible. Precertification requirements for certain services such as ECT, Psych testing and Neuropsych testing. For non-PPO, 20% coinsurance if you live more than 20 miles from PPO provider.
	Mental/Behavioral health inpatient services	No charge	40% of allowed amount + balance	Not subject to deductible. Precertification requirements for certain services such as ECT, Psych testing and Neuropsych testing. For non-PPO, 20% coinsurance if you live more than 20 miles from PPO provider.
	Substance use disorder outpatient services	No charge	40% of allowed amount + balance	Not subject to deductible.
	Substance use disorder inpatient services	No charge	40% of allowed amount + balance	Not subject to deductible.
If you are pregnant	Prenatal and postnatal care	20% coinsurance. No charge for preventive services.	40% of allowed amount + balance	After deductible
	Delivery and all inpatient services	20% coinsurance	40% of allowed amount + balance	After deductible

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% of allowed amount + balance	After deductible
	Rehabilitation services	20% coinsurance	40% of allowed amount + balance	After deductible
	Habilitation services	Not covered	Not covered	Not considered medically necessary
	Skilled nursing care	20% coinsurance	40% of allowed amount + balance	After deductible
	Durable medical equipment	20% coinsurance	20% of allowed amount + balance	After deductible
	Hospice service	20% coinsurance	20% of allowed amount + balance	Not subject to deductible
If your child needs dental or eye care	Eye exam	$5 copay	Up to $45 reimbursed	Provided through Vision Service Plan (VSP). Limited to one exam every 12 months. Lenses - 1 pair every 12 months, only if needed. Frames are limited to one set every 24 months, only if needed. The allowance for frames is $120.00; out-of-network benefits are scheduled.
	Glasses	No charge; $120 frame allowance (glasses or contact lenses)	Up to $47 reimbursed; subject to balance billing.	
	Dental check-up	Dental HMO – No charge Dental PPO – No charge	Dental HMO – Not covered Dental PPO – No charge up to the allowance in fee schedule; subject to balance billing.	Provided by Liberty Dental through a separate trust fund. Employee selects either the dental HMO or the dental PPO.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Genetic counseling
- Hearing Aids
- Infertility Treatment
- Long term care
- Non-PPO substance abuse and mental health services
- Non-Emergency Care when traveling outside the U.S.
- Private Duty Nursing
- Weight loss programs
- Routine foot care

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Routine Eye Care – Adult - Refer to Vision Service Plan (VSP) 1-800-877-7195
- Routine Dental Care – Adult – Refer to Dental Plans through the Teamsters Miscellaneous Security Trust Fund

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly high than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-481-5841. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-(866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-(877-0267-2323 x 61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Plan Administrative office at 1-866-481-5841or the Department of Labor's Employee Benefits Security Administration at 1 (866) 444-EBSA (3272) or www.dol.gov.ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care Help Center at 1-888-466-2219.

Para obtener asistencia en español, llame al número de teléfono en su tarjeta de identificación.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Written translations are available in the following language within 7 business days by contracting plan representatives at the phone number below:

Spanish (Espanol): Para obtener asistencia en Espanol, llame al 1-(800) 533-0119.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $6,740**
- **Patient pays $ 800**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$100
Co-pays	$10
Co-insurance	$540
Limits or exclusions	$150
Total	**$800**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $4,530**
- **Patient pays $900**

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$100
Co-pays	$230
Co-insurance	$460
Limits or exclusions	$80
Total	**$870**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.