SOUTHERN CALIFORNIA DAIRY INDUSTRY SECURITY FUND MENTAL HEALTH & SUBSTANCE USE FOR BLUE CROSS HMO ACTIVE EMPLOYEES AND NON-MEDICARE RETIREES AND PRESCRIPTION DRUGS FOR ACTIVE EMPLOYEES

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: HMO**

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?	**$0** person **/$0** 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 the costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,000** per person / **$6,000** 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, 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. HMC for mental health/substance use; SAV-RX for prescription drugs.	If you use an in-network provider or other health care **provider**, this plan will pay some or all of the costs of covered services. .

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.	The benefits described in this Summary of Benefits only covers Mental Health and Substance Use benefits and Prescription Drug benefits. Other medical benefits are provided by the Blue Cross prepaid HMO Plan

- **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	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Specialist visit	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Other practitioner office visit	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Preventive care/screening/immunization	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only

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 a test	Diagnostic test (x-ray, blood work)	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Imaging (CT/PET scans, MRIs)	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
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
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only

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
	Physician/surgeon fees	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
If you need immediate medical attention	Emergency room services	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Emergency medical transportation	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Urgent care	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
If you have a hospital stay	Facility fee (e.g., hospital room)	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Physician/surgeon fee	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
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	$10 copay/visit	No benefit	
	Mental/Behavioral health inpatient services	No charge	No benefit	
	Substance use disorder outpatient services	$10 copay/visit	No benefit	
	Substance use disorder inpatient services	No charge	No benefit	
If you are pregnant	Prenatal and postnatal care	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Delivery and all inpatient services	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only

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	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Rehabilitation services	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Habilitation services	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Skilled nursing care	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Durable medical equipment	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Hospice service	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
If your child needs dental or eye care	Eye exam	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only
	Glasses	No benefit	No benefit	
	Dental check-up	No benefit	No benefit	Mental Health/Substance Use/Prescription Drug coverage only

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.)**

ANY SERVICES OR SUPPLIES OTHER THAN THOSE FOR TREATMENT OF MENTAL ILLNESS, SUBSTANCE USE, OR PRESCRIPTION DRUGS

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.**

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.

Language Access Services:

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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: Not Applicable -

Deductibles Prescription Drugs and Mental Health/Substance Use only	
Co-pays	
Co-insurance	
Limits or exclusions	
Total	

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: Not Applicable -

Deductibles Prescription Drugs and Mental Health/Substance Use only	
Deductibles	
Co-pays	
Co-insurance	
Limits or exclusions	
Total	

Not applicable – mental health, substance use and prescription drugs only

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.