Southern California Dairy Industry Security Fund

Hospital and Medical Benefit Options For

Active Participants 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

113

SWA Group Number 106
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BENEFITS	FEE FOR SERVICE PLAN
HOSPITAL BENEFITS 1. Room and Board including general nursing care, meals and special diets.	Employee and spouse - covered at 100% when hospitalized at a **Preferred Provider** (PPO) facility. 60% for a non-PPO hospital. 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.	Employee and Dependent - Included as part of #1 above.
3. X-ray examinations; laboratory tests, and physical therapy.	Employee and Dependent - Included as part of #1 above.
4. Drugs, medicines and injections.	Employee and Dependent - 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	Provided for treatment of the totally disabling illness or injury only. See SPD for other applicable limitations.
SURGICAL BENEFITS	80% of allowance for a **PREFERRED PROVIDER PHYSICIAN.** 60% of usual reasonable and customary **NON-PREFERRED PROVIDER PHYSICIAN.**
MATERNITY BENEFITS	Employee and Dependent 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% of allowance for **NON-PREFERRED PROVIDER PHYSICIAN.** Wellness Benefits available. see Plan Booklet.
2. In Office	80% of allowance for a **PREFERRED PROVIDER PHYSICIAN.** 60% of allowance for **NON-PREFERRED PROVIDER PHYSICIAN.** Wellness Benefits available. See Plan booklet.
3. At Home	Same as above
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**	**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) Employee's wife or husband. (b) Employee's unmarried and married children including natural, step-children, legally adopted children or children for whom you have legal custody up to age 26. Dependent children who are eligible for their (or their spouse's) employment based health plan are not eligible. (c) Coverage of a dependent child who attains the age of 26 may be continued while he or she is incapable of self-support because of mental or physical handicap and chiefly dependent upon subscriber or his spouse for support and maintenance.
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 dependents) 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 — when by a Non-PPO provider 9. care or treatment of obesity or weight reduction, including medical, surgical or psychiatric care; 10. maternity care for a dependent daughter 11. 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 independent are eligible under the Plan, if such services are received during the six months following the date of injury 12. care and treatment that is not according to accepted professional standards; 13. 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; 14. inpatient admissions primarily for diagnostic studies when inpatient bed care is not medically necessary; 15. custodial care or rest cures, services provided by a rest home, a home for the aged, a nursing home or any similar facility; 16. optometric services, eye exercises including orthoptics, routing eye exams and routine eye refractions, eyeglasses or contact lenses; and 17. 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
Employee and Dependents — Provided without charge.	Employee and Dependents — Provided without charge.
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Employee and Dependents — Covered in full when determined medically necessary.	Employee and Dependents — Covered in full when determined medically necessary and approved by a Plan physician.
Employee and Dependents — Skilled nursing or convalescent care provided without charge, for 100 consecutive calendar days per disability.	Employee and Dependents — Provided without charge for up to 100 days per calendar year or per spell of illness, whichever is greater.
Employee and Dependents — Provided without charge.	Employee and Dependents — $10.00 per outpatient surgical procedure.
Employee and Dependents — Normal delivery, Cesarean Section covered in full. Prenatal and Postnatal, no charge per visit. See hospital benefits also.	Employee and Dependents — Normal delivery, Cesarean Section covered in full. Prenatal and Postnatal, $5.00 charge per visit. See hospital benefits also. No charge for each x-ray, lab or other tests.
Employee and Dependents — Included in Hospital Benefits.	Employee and Dependents — Included in Hospital Benefits.
Employee and Dependents — Provided without charge.	Employee and Dependents — Provided without charge.
Employee and Dependents — Provided without charge.	Employee and Dependents — Provided without charge.
Employee and Dependents — $10.00 co-payment.	There is a $10.00 co-payment per visit. Special/consultant visits are a $10.00 co-payment per visit.
Provided without charge.	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.
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.**	**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.**
Services provided by PacifiCare physicians and community hospitals, referral hospitals and physicians when determined medically necessary by your Primary Care Physician.	Services provided by Kaiser physicians and Kaiser hospitals.
Emergencies only. WITHIN SERVICE AREA: $50.00 charge if not hospitalized. OUTSIDE SERVICE AREA: $50.00 charge for initial emergency treatment. Continuing or follow-up care made only if provided or authorized by participating medical group. You must notify your participating medical group within 48 hours after an emergency occurs. See PacifiCare Plan documents for details.	Emergencies only. WITHIN SERVICE AREA/KAISER FACILITY: $50.00 co-pay if not hospitalized. OUTSIDE SERVICE AREA/NON-KAISER FACILITY: $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.
Annual co-payment maximum of $2,000.00 per person. Three persons maximum of $6,000.00.	Annual co-payment maximum of $1,500.00 per person. Limited to $3,000.00 per family.
(a) Employee's wife or husband. (b) Employee's unmarried and married children including natural, step-children, legally adopted children or children for whom you have legal custody up to age 26. Dependent children who are eligible for their (or their spouse's) employment based health plan are not eligible. (c) Coverage of a dependent child who attains the age of 19 may be continued while he or she is incapable of self-support because of mental or physical handicap and chiefly dependent upon subscriber or his spouse for support and maintenance.	(a) Employee's wife or husband. (b) Employee's unmarried and married children including natural, step-children, legally adopted children or children for whom you have legal custody up to age 26. Dependent children who are eligible for their (or their spouse's) employment based health plan are not eligible. (c) Coverage of a dependent child who attains the age of 19 may be continued while he or she is incapable of self-support because of mental or physical handicap and chiefly dependent upon subscriber or his spouse for support and maintenance.
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. Nonhuman and artificial organs and their implantation 14. Services related to sexual reassignment surgery 15. Hearing aids, corrective lenses, and eyeglasses, except that Plan physicians provide the services necessary to determine the need therefore and attempt to make arrangements whereby they may be obtained. This exclusion does not apply to lenses covered by Medicare. 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, or 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. Kaiser Permanente has no professional liability for care for conditions for which a member has refused recommended treatment for personal reasons when Medical Group physicians believe no professional acceptable alternative treatment exists. 3. Coverage for physical, occupational, and speech therapies is limited to conditions (including acute phases of chronic conditions) that are subject to continuing significant improvement 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 permanently surgically implanted devices such as pacemakers and hip joints; a prosthesis, 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 and treatment for disruptive or physically abusive patients, court-ordered testing, and methadone maintenance except that methadone maintenance treatment for a pregnant Health Plan member throughout her pregnancy and for two months after delivery, is provided without charge at a licensed treatment center approved by the Permanente 7. Coverage is not provided for internally implanted time-released medications and injectable contraceptives, except as otherwise specifically included.