ACTIVE EMPLOYEES PLAN

Southern California Dairy Industry Security Fund

ATENCIÓN A LOS MIEMBROS QUE HABLAN ESPAÑOL

Si usted no sabe suficiente ingles para poder leer y entender el contenido de este libreto y necesita que alguien se lo explique, por favor comuníquese con la oficina del Administrador al teléfono:

(626) 284-4792 or (877) 350-4792

JUNE 1, 2011 Edition

SOUTHERN CALIFORNIA DAIRY INDUSTRY SECURITY FUND

CURRENT CONTRIBUTING EMPLOYERS

ALEX FRIEDMAN DISTRIBUTORS

BAY VALLEY FOODS

CALIFORNIA DAIRIES, INC.

CHALLENGE DAIRY PRODUCTS

DEAN'S FOOD (ALTADENA)

DRIFTWOOD DAIRY

HEARTLAND FARMS

INSTANTWHIP OF SOUTHERN CA

JON DONAIRE

MARUTYAN DISTRIBUTORS

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STREMICKS HERITAGE FOODS, LLC

SWISS II, LLC

VENTURA FOODS

WESTERN FARMS

WHITE WAVE, INCORPORATED

SOUTHERN CALIFORNIA DAIRY INDUSTRY SECURITY FUND

PARTICIPATING TEAMSTER UNION LOCALS

LOCAL UNION 63

LOCAL UNION 166

LOCAL UNION 186

LOCAL UNION 381

LOCAL UNION 495

LOCAL UNION 542

LOCAL UNION 630

LOCAL UNION 683

LOCAL UNION 952

SOUTHERN CALIFORNIA DAIRY INDUSTRY SECURITY FUND

ACTIVE EMPLOYEES

June 1, 2011 Edition

Notes

Dear Participant:

The Health Plan was established in accordance with Collective Bargaining Agreements between various Teamsters Local Unions and Contributing Employers. The benefits described in this booklet are available to Active Employees working for Contributing Employers who have signed a Collective Bargaining Agreement that requires contributions to the Fund. A separate booklet is available from the Fund Administrator that summarizes benefits for Retired Employees.

This booklet reflects Plan Benefits that are available to you and your family under the Health Fund as of June 1, 2011. It also includes the rules governing eligibility, the filing of claims for the self-funded benefits, your rights to appeal such benefits denials, how benefits are funded and other information about the administration of the Fund as required by the Employee Retirement Income Security Act of 1974 (ERISA).

Some of the benefits available to you are self-funded and provided directly from the assets of the Fund. Other benefits are fully insured and provided through a contract with a carrier. This booklet details the self-funded fee-for-service medical, dental, prescription drug, short term disability benefits and vision benefits, as well as the insured death benefits from a carrier. It also provides a summary of the insured prepaid Kaiser and United Healthcare medical plans. For complete information on the insured benefits, you should refer to the Evidence of Coverage booklet for each carrier. The booklets are available from the Fund Administrator.

Regardless, of the funding method of benefits, none of the benefits available through the Trust are guaranteed. The Trustees reserve the right to amend the type or level of benefits and eligibility rules. From time to time, the Board of Trustees may find it advisable to change the provisions of the Plan and will notify you. To ensure notification, you must provide (in writing) your current address to the Fund Administrator.

We urge you and your family to read this booklet thoroughly so you will be familiar with the enrollment procedures and how to obtain benefits. It should be kept for reference throughout the year when medical care is required. If you have questions about your benefits, eligibility or the filing of claims, please contact the Fund Administrator where the personnel will be happy to assist you. If you are considering your retirement, please contact the Fund's administrative office to request a Dairy Retiree application and a Dairy Fund Retiree booklet to review the Dairy Trust Retiree Qualification Rules for health and welfare benefits.

If you have any questions concerning your Plan, feel free to contact the Fund's Administrative Office at (626) 284-4792 or (877) 350-4792.

Sincerely,

Board of Trustees

Rights of the Board of Trustees

Only the full Board of Trustees is authorized to interpret the Plan benefits described in this booklet, and no individual Trustee, Union Representative, or Employer Representative is authorized to interpret this Plan on behalf of the Board, or to act as an agent of the Board. The Trustees have authorized the Fund Administrator to respond in writing to Plan Participants regarding the administration of the Plan. As a convenience to Participants, the Fund Administrator will provide answers regarding coverage verbally, on an informal basis. However, no such verbal communication is binding upon the Board of Trustees.

The Trustees shall have the exclusive right, power and authority in their sole and absolute discretion to administer, apply and interpret the Plan and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan. The Trustees, in their sole discretion, may amend the Plan by majority vote of the Trustees. Without limiting the generality of the foregoing, the Trustees shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of benefits reimbursed under the Plan.
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;
- Decide questions – including legal or factual questions – relating to the calculation and payment of benefits under the Plan;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other Plan documents; and
- Process and approve or deny benefit claims and rule on any benefit exclusions or limitations.

All determinations made by the Trustees with respect to any matter arising under the Plan and any other Plan documents shall be final and binding on all parties.

Discretionary Authority of the Board of Trustees

The Trustees have full discretionary authority to interpret all Trust Agreement documents and to make all factual determinations concerning any claim right asserted under or against the Plan or Health Fund. The denial of an application or claim after the right to review has been waived or the decision of the Trustees on petition for review has been issued will be final and binding upon all parties, including you. No lawsuit may be filed without first exhausting the above appeals procedure. In any such lawsuit, the determinations of the Trustees are subject to judicial review only for abuse of discretion.

Notice to the Plan

- Masculine pronouns used in the Plan shall apply to both sexes.
- "You" as used in the Plan shall apply to the Active Employee.
- It is important that you notify the Fund Administrator in writing whenever:

    1. You change your home address.
    2. You want to change a beneficiary.
    3. You are receiving worker's compensation benefits.
    4. You return to work after disability ends.
    5. You enter any branch of military service.
    6. You acquire a new Dependent (either through marriage, birth, adoption, etc.)
    7. You have a change of marital status.
    8. You or your eligible Dependent become eligible for other coverage (such as coverage under your spouse's employer or the dependent's employer)
    9. You terminate employment or your Dependent child attains age 26.

Table of Contents

Summary of Plan Benefits

For Active Employees enrolled in the Fee-For-Service Comprehensive Medical Expense Plan

You and your eligible Dependents are covered under all the benefits described in the Schedule of Benefits on pages 26-27. The Fund also covers you for life insurance, disability benefits and prescription drug benefits described in the summary of benefits on page 2. Vision benefits are provided through Vision Service Plan described on page 47. Substance Abuse and Mental Health coverage are provided through the Member Assistance Program. See page 39 for details and contact information. Dental benefits are provided through the Joint Council of Teamsters No. 42 Welfare Trust Fund described on page 19.

For Active Employees enrolled in a Prepaid Medical Plan

You and your eligible Dependents are covered by Kaiser or United Healthcare for hospital and medical benefits. Refer to the separate Kaiser or United Healthcare Disclosure Booklet for a description of those benefits. However, the Fund also covers you for life insurance, disability benefits, dental, and prescription drug benefits described in the summary of benefits on page 2.

If you are enrolled with United Healthcare, you and your eligible Dependents will receive **both** Mental Health and Substance Abuse coverage through the Member Assistance Program. If you are enrolled with Kaiser, you and your eligible Dependents will receive **both** Mental Health and Substance Abuse coverage directly from Kaiser. See page 39 for details.

Summary of Plan Benefits

BENEFITS	COVERAGE AMOUNT
Life Insurance	
Employees.....	$5,000
Dependent Spouse.....	$500
Dependent Child Age:	
Less than 6 Months.....	$100
6 Months, but Less than 2 Years.....	$200
2 Years, but Less than 3 Years.....	$400
3 Years, but Less than 26 Years.....	$500
Employee's Supplemental Weekly Disability Benefits	
Independent Distributors.....	$130 Per Week
Employees Covered by Collective Bargaining Agreement.....	$80 Per Week
Vision Benefits	
Co-payment.....	$5
Frequency:	
Exams.....	Once every twelve (12) months
Lenses.....	Once every twelve (12) months
Frames.....	Once every twenty-four (24) months

Summary of Plan Benefits (Continued)

BENEFITS	COVERAGE AMOUNT
Prescription Drug Program Benefits	
Reimbursement Plan – if you do not live within 15 miles from a Medco Health Pharmacy	75% of Covered Expenses
Card Program – Medco Health Pharmacies	
Walk-In Programs.....	Thirty (30) day supply; $5 generic co-payment; $10 preferred brand name co-payment $25 non-preferred brand name co-payment
Mail-Order Program.....	Ninety (90) day supply; ***mandatory for maintenance Drugs for the third refill and after*** $10 generic co-payment $20 preferred brand name co-payment $35 non-preferred brand name co-payment
Fee-For-Service Comprehensive Medical Expense Benefits	
Annual Maximum Benefit on Essential Health Benefits for plan year beginning on June 1, 2011.....	$750,000 per person
Calendar Year Deductible.....	$100 per person; $300 family maximum
Out-of-Pocket Limit.....	$1,000 of allowable Charges per person per calendar year (in addition to the Calendar Year Deductible)
Coinsurance	
Inpatient Hospital	
PPO[1].....	100% of negotiated rates
Non-PPO.....	60% of allowable Charges
Outpatient Hospital	
PPO[1].....	80% of negotiated rates
Non-PPO.....	60% of allowable Charges
Pre-Admission Testing[2].....	80% of negotiated rates

[1] A PPO Hospital means a Hospital which has a contract with the Fund to provide services at specified fees.
[2] 60% of Allowable Charges if a Non-PPO Hospital is used.

Summary of Plan Benefits (Continued)

BENEFITS	COVERAGE AMOUNT
Emergency Room[1]	80% of negotiated rates
Hospital Charges for Outpatient Surgery	
PPO[2]	80% of negotiated rates
Non-PPO	60% of allowable Charges
Chiropractic Benefits	80%; up to a maximum of 20 visits per calendar year
All Other Benefits	80% of allowable Charges

NOTES:

1. If you do not obtain Pre-Certification before a Hospital admission, **your benefit payments will be reduced by 50%.**

2. If you live more than 20 miles from the nearest PPO provider (or you have an Emergency situation where access to a PPO provider is not available), the Plan will pay benefits at 80% of the allowable Charges. In all other cases, **you must use a PPO provider for your professional and Hospital services for the greatest reimbursement.**

3. The Member Assistance Program provided by Health Management Center/APS **MUST** be utilized before receiving non-Emergency treatment for Mental and Nervous Disorders or Substance Abuse. **Otherwise no benefits will be paid.** [3]

Prepaid Medical Plans

Kaiser	
Hospital	100%
Physician Office Visit	$10
Emergency Room	$50
United Healthcare	
Hospital	100%
Physician Office Visit	$10
Emergency Room	$50

[1] 60% of Allowable Charges if a Non-PPO Hospital is used.
[2] A PPO Hospital means a Hospital which has a contract with the Fund to provide services at specified fees.
[3] Benefits not payable if program is not used.

Summary of Plan Benefits (Continued)

Health Care Reform

The Patient Protection and Affordable Care Act (Affordable Care Act) was signed into law on March 23, 2010. The Affordable Care Act seeks to expand health coverage and provide you with certain rights regarding your health care. This law calls for changes to be made gradually over a period of years. The first set of changes to this Plan will become effective on June 1, 2011, because that is the first day of the plan year beginning on or after September 23, 2010. As of June 1, 2011, the Plan's various benefit packages are "grandfathered". A plan is considered a grandfathered plan if the benefits were in effect on March 23, 2010, at least one participant was enrolled in the plan, and the plan has not made certain types of changes that would otherwise cause it to lose grandfathered status.

This booklet contains important information about changes that are required by the Affordable Care Act. As other changes occur, you will receive additional notices which should be kept with this booklet for your reference.

Eligibility

Employee Eligibility

You are eligible for coverage under this Plan if you are on the Payroll of a Contributing Employer on the first day of the calendar month which immediately follows four (4) full calendar months of employment with the same employer; five (5) full calendar months for eligibility for dental benefits. You are Eligible for benefits based on the Contributing Employer's Collective Bargaining Agreement. A completed Participant Data Form is a requirement for eligibility.

Continued Eligibility

You will continue to be eligible for benefits during each month for which a contribution is received on your behalf.

Transfer of Eligibility

If you transfer from one employer to another operating under the Southern California Master Dairy Agreement within thirty-one (31) days, you become eligible at once, provided you were eligible with the first employer.

Special Enrollment Rights

If you failed to enroll yourself and/or your Dependents, you will have the option to enroll during a Plan year under certain circumstance in accordance with the Health Insurance Portability and Accountability Act (HIPAA) or pursuant to the Plan's rules. The circumstances are:

- You marry or add a Domestic Partner; or
- You have a new Dependent child (either as a result of birth, adoption, placement for adoption of a child, or marriage to a person who has children); or
- Your spouse or Domestic Partner was covered under another group plan and lost eligibility, the expiration of COBRA for your spouse had been reached, or there was a substantial change in the coverage or cost so that the spouse could no longer be covered.

You must request enrollment within thirty (30) days of the termination of your spouse's or Domestic Partner's other coverage or the acquisition of a spouse, Domestic Partner or Dependent child. If you fail to add your dependent(s) within thirty (30) days of your spouse's or Domestic Partner's coverage or the acquisition of a spouse, Domestic Partner or Dependent child, the dependent may not be added at a later date without proper documentation such as a birth certificate, marriage license, etc.

Termination of Eligibility

Your coverage for all hospital, medical, vision, drug expense benefits, life insurance and weekly disability benefits under this program will cease on the first of the following dates:

- The date the Plan is terminated; or

- The last day of the month in which you terminate employment in accordance with a collective bargaining agreement; or

- The last day of the month for which a contribution is due and not paid to the Plan by the Employer on your behalf; or

- The date you enter full time service in the military, naval or air force of any country.

Laid-off employees may continue coverage for thirty-one (31) days from the date of lay-off. Dental benefits will remain in effect for 60 days. If eligibility ends, then you may be entitled to continue coverage under the terms of COBRA (refer to page 12) for details.

Totally Disabled Eligibility Extension

If you are actively employed and become totally disabled and are under the treatment of a Physician, all of your health and welfare benefits (medical, dental, prescription drugs, vision care and life insurance) will be extended for you and your Dependent(s) for the period of your disability, not to exceed twelve (12) consecutive months. The usual plan requirements, co-payments, and maximum benefits allowable apply during your disability period.

The term "totally disabled" as used herein means that you are prevented from engaging in any business, occupation, or employment for remuneration, profit or gain.

Family Medical Leave Act (FMLA)

Under the Family Medical Leave Act (FMLA) your employer must continue to pay for your health coverage during any approved leave. In general, you may qualify for up to 12 weeks of unpaid FMLA leave each year if:

1. Your employer has at least 50 employees;

2. You worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and

3. You require leave for one of the following reasons:

    a. Birth or placement of a child for adoption or foster care,

    b. To care for your child, spouse or parent with a serious medical condition, or

    c. Your own serious health conditions.

As of January 2009, the FMLA also permits an employee to take up to 26 weeks of leave to care for a spouse, son, daughter, parent, or next of kin, who is a: (1) member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, therapy, is otherwise in outpatient status, or is otherwise on a temporary disability

retired list, for a serious injury or illness; or (2) veteran within the meaning of the FMLA. An employee is permitted to take up to 12 weeks of FMLA leave for "any qualifying exigency" (as defined by the Secretary of Labor) for his spouse, son, daughter, or parent, who is deployed with the Armed Forces to a foreign country.

Your employer is required to maintain your coverage during the 12 or 26 week-periods as the case may be.

Details concerning FMLA leave are available from your employer.

In addition to the Plan rules for payment to the Fund because of disability, if your Employer is covered under the FMLA, your Employer may have the responsibility to continue making payments into the Fund for your coverage for 90 days if you are eligible for such coverage. Notify your employer if you believe you are entitled to leave under the FMLA. The entire area of disability and illness is complex. Therefore should you be disabled or ill for any period of time, please notify the Fund Administrator.

Reinstatement

If your coverage terminates for reasons other than disease, injury or lay off and you return to active employment within 31 days of the date such work ceased, coverage will be reinstated on the first day of the month coinciding with the contribution made by your employer. If coverage terminates because of a non-work related disease or injury, you will be eligible for reinstatement if you return to active employment within twelve (12) months of the initial date of disability. ***Exception***: If coverage terminates due to a work related illness or injury and you return to active employment after twelve (12) months, coverage will be reinstated immediately following the first contribution paid by the employer. If coverage terminates due to a lay off and you return to active employment within one year, coverage will be reinstated on the first day of the month coinciding with the first contribution made by your employer. If you do not satisfy these conditions, you must re-qualify as a new employee.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Under this federal act, you may continue coverage for yourself and or your Dependents for up to twenty-four (24) months while you are on military leave. If you make this election, you must submit any self-payment necessary, which may include administrative costs, to the Fund Administrator. For military service of thirty (30) days or less you need only pay your normal share of the contribution, if any. For military service of at least thirty-one (31) days and up to twenty-four (24) months you must submit the full contribution, in addition to any administrative costs of up to 2%, to the Fund Administrator. If you do not continue your coverage during a military leave, it will be reinstated at the same benefit level you received before your leave if you meet the eligibility criteria established under USERRA. For more information about this act, contact the Fund Administrator.

Dependent Eligibility

Your eligible dependents include your lawful spouse and your natural children, adopted children, stepchildren, or children for whom you have legal custody up to 26 years of age.

In addition, your married children include adopted children or children who have been placed in your home for adoption. Coverage for adopted children is effective immediately upon finalization of the adoption or when the child is placed in your home pending adoption. In such cases, the child must be properly enrolled in the Plan, and satisfactory proof of adoption or placement for adoption and commencement of adoption proceedings must be provided to the Fund Administrator. When the child has been placed in the home, but the adoption has not been finalized, the Trustees may require additional proof. Coverage for adopted children will be the same as coverage provided to natural children, step-children, and children for whom you have legal guardianship. In addition, the Plan will provide coverage for dependent children if required by a Qualified Medical Child Support Order (QMCSO).

Federal law requires the Plan to provide coverage for your dependent children under certain circumstances, such as when you and your spouse divorce or legally separate, but in any case as long as the dependent child is your child. A Qualified Medical Child Support Order (QMCSO) is an order issued by a court or a state administrative agency established under state law that meets the requirements contained under the Employee Retirement Income Security Act of 1974 (ERISA). A QMCSO creates or recognizes the existence of a dependent child's right to, or assigns to a child the right to receive medical benefits, provided you are an eligible Participant. Often a state administrative agency will issue an order in the form of a "National Medical Support Notice." Regardless as to the type of order issued, the Fund Administrator must determine that the order is qualified under the terms of ERISA and applicable state law. You may obtain, without charge, a copy of the Plan's QMCSO procedures from the Fund Administrator.

An unmarried child of any age who is unable to earn a living because of mental or physical handicap is also considered eligible for benefits, provided such disabled child was also handicapped and covered as a Dependent prior to age 26 and remains primarily dependent upon the Active Employee for support. You must submit proof of your child's incapacity within thirty-one (31) days after he/she becomes 26. Proof of the continued existence of such incapacity shall be furnished to the Plan office from time to time when requested. Children who reach age 26 prior to the participant's initial eligibility for the benefits of this Plan are not entitled to coverage under these terms.

Note that as long as the benefit package under which you are covered is "grandfathered" under the new health care reform laws, the Fund will deny eligibility to your dependents for ages 19 to 26 if they are eligible for their (or their spouse's) employment-based health plan.

Domestic Partners

Your Dependent may also include your registered Domestic Partner: (1) of the same sex who is age 18 or older; or, (2) age 18 or older and of the opposite sex if one or both of you are age 62 or older and eligible for benefits under the Title XVI of the Social Security Act. In either case, you must provide the Plan with a valid Declaration of Domestic Partnership filed with the Secretary of State. Coverage under the Plan is not provided for the dependent children of a Domestic Partner. Unless your Domestic Partner is eligible as your dependent under the Internal Revenue Code, the benefits provided for your Domestic Partner will be taxable. You will be required to prepay the quarterly (employer and employee) taxes on the value of benefits received (imputed income) for your domestic partner. If you wish to enroll a Domestic Partner, you must contact

the Fund Administrator for a packet of materials that need to be completed, and information on the taxes that will be payable.

Effective Date of Dependents' Eligibility

If you have dependents on the date you become eligible, each Dependent becomes eligible on the same date. New Dependents become eligible when acquired and properly enrolled.

Termination of Dependents' Eligibility

Your Dependents' eligibility terminates on the earliest of the following:

- The day your eligibility terminates;
- The date the person is no longer a Dependent as described above;
- The date of termination of a Domestic Partnership relationship;
- The date the person enters into full-time military service;
- The date of your death;
- The date the Dependent becomes covered as an employee by the Fund; or
- The date of termination of the Plan

If the eligibility ends, then you may be entitled to continued coverage under the terms of COBRA (refer to page 12) for details.

The Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) require this Plan to furnish you with certain information. HIPAA seeks to help families minimize the impact of pre-existing condition exclusions as they move from job to job. A pre-existing condition is a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period prior to an individual's enrollment date. A pre-existing condition exclusion means a medical plan may not cover certain illnesses (for example, a heart condition) until an individual is covered under the Plan for a designated period – typically, six (6) to twelve (12) months. This Plan does not contain any pre-existing condition exclusions. When you become eligible for benefits, all benefits become effective on that date.

Certificate of Group Health Plan Coverage

When you lose eligibility under this health plan, you will be furnished with a "Certificate of Group Health Plan Coverage." This certificate provides you with evidence of your prior health coverage with this Plan. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions before you enroll. This certificate may need to be provided if medical advice, diagnosis, care or treatment was

recommended or received for the condition prior to enrollment in the new plan. Upon request, you can obtain a copy of the Certificate of Group Health Plan Coverage for a period of twenty-four (24) months from the date of loss of coverage. Please see page 82 for a copy of the form to request a Certificate of Group Health Plan Coverage.

If you become covered under another group health plan, check with the plan's administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance plan that does not exclude coverage for medical conditions present before you enroll.

Continuation Coverage Rights Under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

Note: Domestic Partners are not eligible for continuation of coverage under the federal law. If eligibility ceases, the dependent may be able to purchase a conversion policy from the carriers.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Active Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of one of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than for your gross misconduct.

If you are the spouse of an Active Employee, you will become a qualified beneficiary ***if you lose your coverage*** under the Plan because of any of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or hers gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because of any of the following qualifying events:

- The parent-Active Employee dies;
- The parent-Active Employee's hours of employment are reduced;

- The parent-Active Employee's employment ends for any reason other than his or her gross misconduct;

- The parent-Active Employee becomes entitled to Medicare (Part A, Part B, or both);

- The parents become divorced or legally separated; or

- The child stops being eligible for coverage under the Plan as a "Dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Active Employee, commencement of a proceeding in bankruptcy with respect to the Contributing Employer, or the Active Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the Fund Administrator will provide you with notification of your rights to COBRA continuation coverage.

You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce or legal separation of the Active Employee and spouse or a Dependent child losing eligibility for coverage as a Dependent child), you must notify the Fund Administrator in writing within sixty (60) days after the qualifying event occurs.

The Fund is the Southern California Dairy Industry Security Fund. The Board of Trustees of the Plan has contracted with a third party, Southwest Administrators, Inc., to administer the day-to-day matters of the Fund, including COBRA.

You must send notice of a qualifying event to:

SOUTHWEST ADMINISTRATORS, INC.

Mailing Address:
Post Office Box 1121
Alhambra, CA 91802-1121

Street Address:
1000 South Fremont Avenue, A-9 West
Alhambra, CA 91803
(626) 284-4792 (877) 350-4792
www.swadmin.com

Information and Documentation Required for Notification of a Qualifying Event

Your written notice of a qualifying event must include sufficient information for the Fund Administrator to be able to identify you, along with the type and proof of the qualifying event. Identification should include the Active Employee's name, your name (if a Dependent), Social Security Number of the Active Employee or the Active Employee's I.D. number and the address and telephone number where you can be reached.

Proof of a qualifying event should include any of the following applicable documentation: a copy of the divorce decree or legal separation; a copy of the certified death certificate; a copy of a marriage license, a copy of the birth certificate or legal placement of a child for adoption; or a copy of a Social Security Disability award.

How is COBRA Coverage Provided?

Once the Fund Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Active Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Active Employee, the Active Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of thirty-six (36) months. When the qualifying event is the end of employment or reduction of the Active Employee's hours of employment, and the Active Employee became entitled to Medicare benefits less than eighteen (18) months after the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a covered Active Employee becomes entitled to Medicare eight (8) months after the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally last for only up to a total of eighteen (18) months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

If you are not eligible for COBRA, you will receive notification from the Fund Administrator indicating why COBRA is not available.

Your COBRA self-payment extension period will run concurrently with any extensions provided by the Fund, such as when you are laid off or totally disabled. For example, assume you are laid off from employment and your coverage under this Fund terminates. After you receive a 31-day extension of free coverage (at no cost to you), you will have the right to elect and pay for COBRA for up to 17 additional months (since COBRA's duration for the qualifying event of termination of employment is 18 months).

Disability Extension of 18-month period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Fund Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started within sixty (60) days before or after the date you lost coverage and must last at least until the end of the eighteen (18) month period of continuation coverage. If you are totally disabled within these periods and you receive a Social Security disability determination before the initial eighteen (18) months of continuation coverage expires and report that determination to the Administrative Office within sixty (60) days of the date you receive notice, then your coverage and that of your enrolled COBRA family members may be continued for an additional eleven (11) months (a total of no more than twenty-nine (29) months, unless otherwise terminated earlier. COBRA premiums are higher for the extra eleven (11) months of coverage. (Refer to page xx for the required documentation)

Second Qualifying event extensions of (18) month period of continuation coverage

If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum total of thirty-six (36) months, if written notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the Active Employee or former Active Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

What benefits can be continued under COBRA?

When you experience a qualifying event, you will be given the option of continuing most of the benefits you had on the day before your loss of coverage. Under COBRA, you cannot continue life insurance or the short term disability benefits. You will have the option of continuing only your medical and prescription drug benefits or your medical, prescription drug, dental and vision benefits. While you are electing coverage or continuing coverage under COBRA, if the benefits for Active Employees and their Dependents change, the benefits you have will also change.

What is the Cost of COBRA continuation coverage?

The cost for COBRA continuation coverage depends upon the coverage you elect to continue and the type of qualifying event:

- You will be required to pay 102% of the full costs for those benefits for a qualifying event that provides eighteen (18) months or thirty-six (36) months of COBRA coverage.

- During the disability extension period (additional eleven (11) months of COBRA continuation coverage) you will be charged 150% of the cost of coverage continued.

Premiums for COBRA coverage may be changed for all COBRA Participants once each year.

How do I make COBRA payments and when are they due?

When you experience a qualifying event, you will receive a separate notice of your rights to continue coverage under COBRA. The notice will advise you of your options and the cost of the benefits.

You will have sixty (60) days from the date you lost coverage (the election period) during which you must inform the Fund Administrator that you want continuation coverage.

Your first payment must be received within forty-five (45) days from the date you have made your timely election for COBRA continuation coverage.

The first payment must include the cost for benefits from the date of loss of coverage to the first day of the month of your first payment.

Subsequent COBRA payments are due on the first day of the month and will be considered delinquent if not received within thirty (30) days. If your payment is delinquent, COBRA coverage will cease and it cannot be reinstated.

What happens if I need to have services before I have made my election and payment for COBRA coverage?

Technically, you do not have coverage until you have paid the COBRA payment for that month of coverage. If a provider calls to verify your coverage during this period, they will be told that services will only be covered if the COBRA payment is received in a timely manner. You may be required to pay for services in advance. In the event you do receive services for which a Plan payment was made, you will be responsible for reimbursement to the Plan if it has paid any claims in error.

Termination of COBRA continuation coverage

You may lose your continuation coverage before the end of your maximum coverage period for any of the following reasons:

1. If the required COBRA payment is not paid in a timely manner, coverage will cease;

2. If you first become covered under another group health plan, after the date of COBRA election, that does not contain any applicable exclusion or limitation with respect to any preexisting condition. (This rule applies only to the qualified beneficiary who becomes covered by another group health plan.);

3. If all group health plans are terminated;

4. If you, your spouse, or your dependent children first become entitled to Medicare coverage after the date you elected COBRA continuation coverage, coverage will cease for the person who becomes entitled to Medicare. Entitlement to Medicare

benefits occurs upon the effective date of enrollment in either Part A or Part B, whichever occurs earlier. Mere eligibility for Medicare is insufficient.

5. If you have continued coverage due to a disability determined by the Social Security Administration (SSA) beyond the initial 18-month period, coverage for you and all your qualified beneficiaries will end with the first month beginning more than 30 days after the SSA makes a final determination that you are not or are no longer disabled;

6. You request cancellation of COBRA coverage in writing;

7. If you or your Dependents commit fraud or intentional misrepresentation; and

8. The date your former employer no longer contributes to the Plan, if the employer continues to provide coverage for any of its employees, who were previously covered by this Plan. There are exceptions to this rule, so this will be decided on a case by case basis.

Plan or Benefit Changes

As a qualified beneficiary, you are entitled to the same open enrollment rights as Active Employees. Although you may only continue benefits you had on the day before a qualifying event, you may change plans during the open enrollment period.

Plan benefits may be modified or amended during the period of your COBRA continuation coverage which may result in a change in premiums. Your COBRA premiums will be based upon the benefits you have.

You are also entitled to HIPAA special enrollment rights such as adding coverage for newly acquired family members or when an eligible individual declines coverage due to alternative coverage and later loses such coverage due to certain qualifying reasons.

Conversion Option

When your coverage ends, you have the option of converting your group coverage to an individual plan if conversion is available. You have sixty (60) days to convert your coverage. You should contact your insurance carrier for information on conversion plans and their costs prior to the date of your loss of coverage. Conversion plans do not provide the same level of coverage as the plan for Active Employees and Dependents, and they generally cost more.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Fund Administrator informed of any changes to your and family member's addresses. You should also keep a copy, for your record, of any notices you send to the Administrator.

California COBRA Option

If you have a qualifying event that results in less than thirty-six (36) months of coverage, and you have maintained that coverage for the maximum period of time, you may be eligible to continue your medical coverage for an additional period of time under California COBRA. This coverage is only available to Participants enrolled in the Kaiser or United Healthcare prepaid medical plans. You can receive additional information from the carriers. Premiums for this coverage are 110% of the cost or 150% of the cost, if the person is disabled as determined by the Social Security Administration.

Choice of Medical and Dental Plans for You and Your Dependents

Medical Benefits

Three medical benefit Plan options are available to you and your eligible Dependent(s).

- **A Fee-For-Service Plan provided directly through the Fund.** If you are enrolled in this option, you and your eligible Dependent(s) will be covered under the Fund's Fee-For-Service Comprehensive Medical Expense Plan for hospital and medical services and supplies. You may use any Physician or Hospital in the United States as those terms are defined in the Plan (see Definitions). If you choose a provider in the First Health PPO network, you will reduce your out-of-pocket expenses. Please contact the Fund Administrator to obtain a list of the current PPO providers. You can also visit Southwest Administrator's website at www.swadmin.com which has a link to First Health's Provider Directory and other valuable information. However, your prescription drug benefit will be provided by Medco Health described later in this booklet.

- **A Prepaid Health Plan provided through United Healthcare.** You must live or work within 30 miles of a United Healthcare Medical Group or Independent Physician Association (IPA) in order to enroll in this plan. If you enroll in this plan, you and your eligible Dependent(s) will be covered under the United Healthcare Plan for all Hospital and medical services and supplies. However, your prescription drug benefits will be provided by Medco Health as described in this booklet.

- **A Prepaid Health Plan provided through Kaiser Foundation Health Plan.** You must live or work within 30 miles of a Kaiser medical facility in order to enroll in this plan. If you enroll in this plan, you and your eligible Dependents will be covered under the Kaiser plan for all Hospital and medical services and supplies. However, your prescription drug benefits will be provided by Medco Health as described later in this booklet.

From time to time, the prepaid plans may change. You will be notified in advance of such changes and be offered an opportunity to select any provider available.

Whichever plan you select, you will have the option to change plans once you have been on your current medical option (Fee-For-Service, Kaiser or United Healthcare) for twelve (12) months. You may call the Fund Office to request enrollment information and make a change to another medical option at any time. You may not make a change again until after you have remained on the new coverage for twelve (12) full calendar months. A newly eligible Active Employee and his/her Dependent(s) will be automatically enrolled in the Fee-For-Service Plan provided by the Fund, unless he/she specifically signs up for United Healthcare or the Kaiser plan. A description of the Fee-For-Service Comprehensive Medical Expense plan provided by the Fund is included in this booklet. Descriptions of the Prepaid Plans are in the separate Kaiser and United Healthcare booklets.

Dental Benefits

Three dental enrollment plans options are available to you and your eligible Dependent(s). These plans are provided through the Joint Council of Teamsters, No. 42 Welfare Trust Fund and the complete benefit descriptions and rules may be found in the Joint Council of Teamsters, No. 42 Welfare Trust Fund Summary Plan Description. A newly eligible Active Employee and his/her Dependent(s) will be automatically enrolled in the Fee-For-Service Plan provided by the Fund, unless he/she specifically signs up for one of the Prepaid Dental Plans. If you wish to enroll in a prepaid plan you may do so **only** during the open enrollment period held each year. Once you have made this choice you may not change to the Fee-For-Service Plan or any other prepaid dental plan until the next annual enrollment period. For further information regarding these dental options, and for information regarding your orthodontia benefits, please contact the Fund's Administrative office.

Vision Benefits

Vision benefits are provided through Vision Service Plan (VSP). You may use any VSP licensed eye doctor of your choice. Contact VSP directly at (800) 877-7195 or visit their web site at www.vsp.com for a list of VSP providers and information on how to use the plan. You can also visit Southwest Administrators' website at www.swadmin.com which has a link to VSP's provider directory and other valuable information.

Life Insurance Benefits
for All Eligible Active Employees
and Their Dependents

Insured by the Union Labor Life Insurance Company (ULLICO)

Employees

If you die from any cause while you are insured, $5,000 will be paid to your beneficiary.

Beneficiary

You may name any person or persons you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form. Contact the Fund Administrator for the necessary form. The change will be effective when the completed form is received by the Fund Administrator.

If you name more than one beneficiary, but you do not indicate how much each should receive, the beneficiaries will be paid equal amounts. If you do not name a beneficiary, or if your beneficiary dies before you, the proceeds will be payable in the following priority:

1. your surviving spouse or Domestic Partner;
2. your surviving children, in equal shares;
3. your surviving parents, in equal shares;
4. your surviving brothers and sisters, in equal shares;
5. your executors or administrators of your estate.

Total and Permanent Disability – Life Insurance

If you become totally and permanently disabled before age 60, your life insurance will continue at no cost to you for twelve (12) months from the date premiums were paid on your behalf. Coverage will continue during such disability, without payment of premium, if:

1. you send written proof of your disability to ULLICO no later than twelve (12) months after the start of your disability; and

2. the proof shows that you were Totally and Permanently Disabled for at least nine (9) months and that such disability will presumably continue to exist.

Premiums will be waived every twelve (12) months if you submit proof of continuing total and permanent disability each year, within three (3) months of the anniversary date that ULLICO received the initial proof of your disability.

Amount of Insurance that is Continued

While you are totally and permanently disabled, you will receive the amount of life insurance that you were receiving at the time your premium payments ceased due to your disability.

Meaning of Totally and Permanently Disabled – Life Insurance

You will be considered "totally and permanently disabled" if due solely to illness or injury, you are prevented from engaging in any business, occupation, or employment for remuneration or profit.

Benefits Will Continue

Benefits will continue under this extension until the earliest of:

1. Thirty-one (31) days after the date you are no longer totally and permanently disabled;

2. The date you fail to furnish ULLICO with proof of your continued disability.

3. The date you failed to be examined by a Physician designated by ULLICO, if so requested by ULLICO. Such an examination will not be required more than once a year after your insurance has been continued under this extension for two (2) full years.

Conversion Privilege

If you are no longer eligible for group life insurance because you no longer belong to an eligible insured class or if you terminate your employment, you may convert that benefit to a form of individual life insurance offered by ULLICO, except for term insurance.

You will not need a medical examination. You must complete the application form and send it with the first premium payment to ULLICO no later than thirty-one (31) days after your group life insurance has terminated.

The face value of your new policy cannot be more than the amount you had under the group plan. The rate you pay will depend on your age (at the nearest birthday to the date of issue of the individual policy), your class of risk at the time of your conversion, and the face value of your new policy.

You may also convert if your life insurance benefits terminate because the policy terminates, or because life insurance benefits for your class terminate. In this case, however, you must have been covered under the group plan for at least five years. You may convert the LESSER of the following amounts:

1. The amount of life insurance you had under this Plan, less any new amount you may have or for which you may become eligible under another group plan within thirty-one (31) days of the termination; or

2. $2,000.00

If you should die during the thirty-one (31) day period after your group life insurance has terminated, ULLICO will pay the amount of life insurance you could have converted to the last beneficiary you named, whether or not you applied for an individual life insurance policy.

You should contact the insurance carrier for more information about conversion options.

Dependent's Life Insurance Benefits

Life insurance is provided for your Eligible Dependent(s) in the following amounts:

Your legal spouse or Domestic Partner	$500

Your children:

Less than 6 months of age	$100
6 months, but less than 2 years	$200
2 years, but less than 3 years	$400
3 years, but less than 26 years	$500

Beneficiary for Dependent's Life Insurance

The Active Employee is the beneficiary of his Dependent's Life Insurance. In the event the Employee dies before the Dependent, the Dependent's Life Insurance proceeds will be payable on his/her death to the executors or administrators of the Dependent's estate or at ULLICO's option to any one or more of the Dependent's surviving relatives: father, mother, child(ren), brother, or sisters.

Conversion Privilege

If your Dependent's Life Insurance terminates for any reason, he or she may convert that benefit to any form of life insurance usually offered by ULLICO, except for term insurance.

A medical examination will not be required. However, the application form and the first premium payment must be sent to ULLICO no later than thirty-one (31) days after the life insurance coverage has terminated. If your Dependent dies during this thirty-one (31) day period, ULLICO will pay the life insurance benefits whether or not your Dependent had applied for conversion.

The face value of the new policy cannot be more than the amount under the group Plan. The rate charged will depend upon your Dependent's age, class of risk at the time of conversion, and the face amount of the new policy.

The converted policy will become effective on the thirty-second (32nd) day following the date his life insurance coverage terminated.

If you should have any questions regarding conversion options, please contact the Fund Administrator for more information.

Supplemental Occupational and Non-Occupational Disability Benefits for Eligible Active Employees Only

If you are disabled and unable to work as a result of an occupational or non-occupational injury or disease, you will be entitled to a maximum payment of $18.14 per day for Independent Distributors and $11.43 per day for eligible Active Employees covered by a Collective Bargaining Agreement, beginning on the fourth (4) day of disability. Beginning on the eighth (8) day of disability, or on the first day of Hospitalization if earlier, your benefit will be at the rate shown below for your classification, not to exceed twenty-six (26) weeks of benefits for any one disability. The Fund may deduct appropriate taxes as may be required by State or Federal law.

	Weekly Rate of Supplemental Benefits
Independent Distributors	$130
Eligible Employees covered by Bargaining Unit	$80

Successive periods of disability separated by less than two (2) weeks of active full-time work will be considered one period of disability unless the subsequent disability is due to an injury or disease entirely unrelated to the cause of the previous disability and commences after return to active full-time work with the Contributing Employer.

Determination of Disability

House confinement during your disability is not required. However, the disability must be of sufficient severity to prevent you from engaging in any business, occupation, or employment for remuneration, profit, or gain and you must be under the care of a licensed Physician.

Refer to pages 55 through 56 for information on the timing of benefit determinations.

Fee-For-Service Comprehensive Medical Expense Benefits For Eligible Active Employees and Their Dependents

Your Comprehensive Medical Expense Plan contains a mandatory Hospital Pre-admission and Continued Stay Review Program, a mandatory PPO Physician and Hospital network, and a mandatory Member Assistance Program. Each of these programs is described fully on pages 36 through 38.

Benefits may be reduced or denied unless you use these programs, so be sure to read the relevant pages of this booklet carefully.

SAVE MONEY

If you use PPO doctors and PPO Hospitals, your out-of-pocket expenses will be reduced. These doctors and Hospitals have contracted with the Fund to provide services at a set fee. For further details of this Plan, (known as the PPO Plan) see page 37. **PPO directories are available at no charge from the Fund Administrator or you can visit Southwest Administrator's website at www.swadmin.com and link to the First Health Network Provider Directory. Your password is (sdg). You may also call the First Health PPO Information Hotline at (800) 559-8723. Be sure to tell them you are covered by the Southern California Dairy Industry Security Fund.**

Many of the terms used in this booklet have a very precise meaning. To be sure you understand the meaning of these terms, please refer to the "Definitions" section of this booklet which begins on page 63.

The following charts show the benefits available under the Fee-For-Service comprehensive medical expense benefits plan:

Calendar Year Deductible	$100 per person per Calendar Year; $300 per family per Calendar Year Maximum
Annual Maximum Benefit for Essential Health Benefits	$750,000 per person
Out-of-Pocket limit	$1,000 per person per Calendar Year (in addition to the Calendar Year Deductible)

Fee-For-Service Comprehensive Medical Schedule of Benefits for Active Employees and Dependents

Benefit	PPO	Non-PPO
Ambulance	80%	80%
Air Ambulance	80%	80%
Anesthesiologist	80%	60%
Assistant Surgeon	80%	60%
Birthing Center (*Same as Hospital delivery*)	80%	60%
Chiropractic Care (Limited to 20 visits per year)	80%	
Durable Medical Equipment	80%	80%
Hearing Aid	Not Covered	Not Covered
Home Health	80%	Negotiated
Hospital – Inpatient	100%	60%
Hospital – Outpatient	80%	60%
Hospital – Other Charges	80%	60%
Hospice – in lieu of Hospitalization; not subject to deductible	80%	80%
Immunizations – Routine only as recommended by the American Academy of Pediatricians	80%	Not Covered
Outpatient Diagnostic X-ray and Laboratory	80%	60%
Outpatient Surgeon and Facility Charges	80%	60%
Physical Exam – Employees, Spouses and Domestic Partners are allowed up to $500 per visit. Physical examinations for Dependent Children.	80%	Not Covered
Physician Office Visits	80%	60%
Prescription Drugs – Retail Generic Preferred Brand Non-Preferred Brand	 $5.00 $10.00 $25.00	75% of Covered Expenses – if you live more than 15 miles from a Medco Health pharmacy
Prescription Drugs – Mail Order Generic Preferred Brand Non-Preferred Brand	 $10.00 $20.00 $35.00	 N/A N/A N/A
Mental Health Services – Outpatient (Maximum of 25 visits per Calendar Year)	100%	Not Covered
Mental Health Services – Inpatient (Maximum of 50 days per Calendar Year)	100%	Not Covered

Benefit	PPO	Non-PPO
Routine Nursery Care	80%	Not Covered
Routine Mammogram Benefits – Up to $500 per visit	80%	Not Covered
Substance Abuse Treatment (*Outpatient* up to a maximum of 25 days per calendar year. Inpatient up to a maximum of 10 days per calendar year; maximum of 3 episodes per lifetime.)	100%	Not Covered

How Do the Comprehensive Medical Expense Benefits Work?

After the calendar year "Deductible" is satisfied, the Plan will pay the stated percentages for "Covered Expenses" until the patient's "Out-of-Pocket" expenses (expenses which result from the percentage of Covered Expense not payable by the Plan), total $1,000 of Allowable Expenses during the calendar year. When this $1,000 of Allowable Expenses Out-of-Pocket limit is reached, the Plan pays 100% of Allowed Expenses incurred thereafter during the same calendar year by that same individual, subject to the "Annual Maximum Benefit" and any other limits on benefits. However, the Out of Pocket Limit provision does not apply to certain expenses. Please see the section below entitled Out of Pocket Limit for further details.

Calendar Year Deductible

You are responsible for the first $100 of Covered Expenses that you incur in a calendar year. This is called your "Deductible." The deductible each calendar year applies separately to you and each member of your family, up to a maximum of $300 per family.

In order that the Deductible will not be applied late in one calendar year and soon again in the following year, any Covered Expenses incurred in the last three months of a year, which are applied toward the Deductible, may also be applied toward the Deductible for the following year.

If two or more eligible family members are injured in the same accident, only one Deductible will apply to Covered Expenses resulting from the accident during the calendar year in which the accident occurs.

Out-of-Pocket Limit

The Out-of-Pocket Limit is $1,000 of Allowable Charges per person per calendar year. This means that after the Deductible has been satisfied, the maximum a covered person must pay for certain Covered Expenses during s calendar year is $1,000 of Allowable Charges, subject to the Annual Maximum Benefit. However, expenses for any non-covered services and supplies including any charges in excess of Allowable Charges may not be used to satisfy the co-payment limit.

Annual Maximum Benefit

The Annual Maximum Benefit on Essential Health Benefits is $750,000 per person for the plan year beginning on June 1, 2011. This means that no more than $750,000 will be paid under the Comprehensive Medical Expense on account of each covered person.

Women's Health and Cancer Rights Act of 1998

Any Participant or beneficiary who is receiving benefits under this Plan in connection with a mastectomy and who elects breast reconstruction, the above titled law requires coverage in a manner determined in conclusion with your attending Physician for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and

- Prostheses and treatment of physical complications at all stages of mastectomy; including lymphedemas.

This coverage is subject to the Plan's annual deductibles, coinsurance and other relevant provisions of the fee-for-service Plan as well as those provisions found in a Health Maintenance Organization with whom this Plan has contracted.

If you have any questions about whether your plan covers mastectomies or reconstructive surgery, please contact your Fund Administrator at (626) 284-4792 or (877) 350-4792.

Newborn's and Mother's Health Protection Act

Under federal law, group health plans and health insurance issuers generally may not, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following normal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not require that a provider obtain authorization from the Plan issuer for prescribing a length of stay that is forty-eight (48) hours or ninety-six (96) hours or shorter.

Covered Expenses

Covered Expenses are charges for the services and supplies listed which are certified by the attending Physician to be "Medically Necessary" for the care and treatment of injury or sickness (Refer to the definition of "Medically Necessary.")

This means that services and supplies which are not Medically Necessary, such as custodial nursing, are not covered by the Plan. Covered Expenses for a particular service or supply do not include charges which are more than the amount considered allowable by the Fund for that particular service or supply. (Refer to the definition of "Allowable Charges.")

Hospital Services

Need to go to the Hospital? You should use PPO Hospitals if accessible. Benefits will be paid at a lower percentage of Allowable Charge if non-PPO Hospitals are used.
REMEMBER – except for Emergency admissions, you must obtain a Hospital pre-admission review before being admitted to the Hospital. See pages 36 through 38.

Inpatient Confinement

PPO Hospitals. If you or your Dependent(s) become confined in a PPO Hospital, the Plan will pay 100% of the negotiated charges incurred for room and board (including confinement in an intensive care unit) and other necessary services and supplies obtained during the confinement.

Non-PPO Hospitals. If you or your Dependent(s) become confined in a Non-PPO Hospital, the Plan will pay 60% of the Allowable Charges (refer to the Schedule of Benefits on page 26) incurred for the following:

- Room and board charges, up to an amount equal to the Hospital's most common charge for its standard semi-private accommodations;
- Intensive care unit accommodations, not to exceed an amount equal to two times the Hospital's most common charge for its standard semi-private accommodations;
- Other miscellaneous services and supplies that are necessary for treatment of injury or sickness.

However, if you normally reside beyond 20 miles from a PPO Hospital, or if you are admitted on an Emergency basis (for sudden onset of illness or for accidental injuries) to a non-PPO Hospital, you will be entitled to full Plan benefits.

Outpatient Services

- If you or your Dependent(s) are not confined in a Hospital (you must use a PPO Hospital when accessible) as a registered bed patient, but undergo a surgical operation or incur charges in connection with Pre-Admission Testing prior to a scheduled Hospital stay, the Plan will pay a percentage of the Hospital's negotiated charges for necessary services and supplies other than Physician services based on the previous chart. Use of a non-PPO Hospital is payable at a lesser percentage of Allowable Charges.
- If you or your Dependent(s) are not confined in a Hospital (you must use a PPO Hospital when accessible) as a registered bed patient, but incur expenses for Emergency room use, supplies, ancillary services, Drugs, and medicine for the first treatment of shock, hemorrhage, acute poisoning, or for treatment of accidental injuries received within forty-eight (48) hours of the injuries, the Plan will pay 80% of the Hospital's negotiated charges for such expenses based on the Schedule of Benefits on pages 26-27. Use of a non-PPO Hospital is payable at 60% of Allowable Charges and results in higher out-of-pocket expenses for you, based on the same Schedule of Benefits.

Home Health Care

The Plan will pay 80% of the Allowable Charges you or your Dependent(s) incur for the following services from a Home Health Agency:

- Services of a Registered Nurse;
- Services of a licensed therapist for physical therapy, occupational therapy, and speech therapy;
- Services of a medical social service worker;
- Services of a health aide who is employed by (or under an arrangement with) a Home Health Agency. Services must be ordered and supervised by a Registered Nurse employed by the Home Health Agency as a professional coordinator. These services are only covered if you or your Dependent(s) are also receiving the services listed in one of the first two items above; and
- Necessary medical supplies provided by the Home Health Agency.

Conditions of Service. The benefits described above will only be payable if the following conditions are met:

- You or your Dependent(s) must be confined at home under the active medical supervision of a Physician ordering home health care and treating the illness or injury for which that care is needed;
- Services must be provided and billed by the Home Health Agency; and
- Services must be consistent with your or your Dependent's illness, injury, degree of disability, and medical needs. Benefits are provided only for the number of days required to treat the illness or injury.

Hospice Care

The Plan will pay 80% of the Allowable Charges incurred for the following services received by you or your eligible Dependent(s) during a period for which a Physician has indicated a prognosis of less than six months to live. The percentage of the Allowable Charge will be higher if you use a PPO, and lower if you use a non-PPO:

- Inpatient care in a free-standing Hospice Facility (the Plan will not cover more than three weeks of such care without prior approval);
- Outpatient care by a Home Health Agency (the Plan will not cover more than 7 days for outpatient Hospice Care, except with prior approval);
- Medical social services.

Benefits for inpatient Hospice Care may not exceed more than six (6) consecutive months of care.

Chiropractic Benefits

The Plan will pay 80% of the Allowable Charges incurred by you or your Dependent(s) for treatment provided by a chiropractor, up to a maximum of 20 visits per calendar year. In addition, benefits for X-rays ordered by a chiropractor will be limited to a maximum of one such set of X-rays per calendar year.

Mental Health and Substance Abuse

Regular Plan benefits will be paid for charges incurred in connection with the treatment of mental and nervous disorders or substance abuse provided you utilize the Member Assistance Program. However, there is an annual maximum of 25 visits of outpatient care and 50 days of inpatient care for the treatment of mental and nervous disorders. For charges related to the treatment of alcoholism or drug addiction, there is an annual maximum of 25 visits for outpatient care. For charges related to the treatment of alcoholism or drug addiction, there is an annual maximum of 10 days of inpatient care, up to a maximum of 3 Episodes per lifetime.

In certain circumstances, these benefits may be reduced. Please refer to page 39 for further information concerning the Member Assistance Program.

Wellness Benefit

The Plan will pay a percentage of the Allowable Charges incurred for routine physical examinations received only from a PPO contracting provider as follows:

- **Employee and Spouse**
  Up to $500 per visit

- **Dependent Children**
  Routine immunizations, checkups, and physical examinations in accordance with the schedule recommended by the American Academy of Pediatrics and the American Academy of Family Physicians.

No benefit is available for out-of-network wellness care.

Other Services and Supplies

The Plan will pay 80% of the Allowable Charges incurred for the following:

- Services of a PPO Physician;

- Services of an anesthesiologist;

- Services of a Registered Nurse;

- X-ray, radium, and radioactive isotope therapy; provided by a PPO Provider;

- Physical therapy treatments provided by a registered physical therapist who is a PPO Provider;

- Required x-ray and laboratory examinations provided by a PPO Provider;

- Ambulance trips to and from local Hospitals;

- Artificial limbs, eyes, casts, splints, trusses, braces, crutches, the rental of wheel chairs, Hospital-type beds, or iron lungs needed for conditions occurring while covered by the Plan; and

- Blood transfusions, including the cost of blood and blood plasma.

Extended Benefits

In the event of loss of employment and your coverage ceases (see pages 6 through 7 "Termination of Eligibility"), if you or your Dependent(s) are totally disabled on the date your eligibility ends and are under the care of a Physician, Comprehensive Medical Expense Benefits may continue to be provided for the treatment of the totally disabling illness or injury only. These benefits are provided until the first of the following occurs:

- The date the total disability ceases; or

- The Plan maximum has been paid; or

- A period of twelve (12) consecutive months has passed since the date coverage ended.

IMPORTANT NOTE: Benefits are not extended for any person other than the person with the total disability and benefits are payable only for treatment of that totally disabling illness or injury.

Limitations and Exclusions

In addition to the General Limitations and Exclusions listed on page 46, and any limitations or exclusions contained in this booklet, Comprehensive Medical Expense Benefits are not payable for expenses incurred in connection with:

- Reconstruction of prior sterilization procedures;

- Hearing aids;

- Any procedure or treatment designed to alter the physical characteristics of the individual to those of the opposite sex;

- 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;

- Inpatient Hospital charges in connection with a Hospital stay primarily for physical therapy;

- Cosmetic surgery or other services for beautification, except to correct functional disorders or as a result of accidental injury provided services are incurred within twelve (12) months of the date of injury or illness;

- 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;

- Routine physical examination, except as specifically provided;

- Care or treatment of obesity or weight reduction, including medical, surgical or psychiatric care;

- Maternity care for a Dependent child;

- 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 Dependent are eligible under the Plan, if such services are not received during the six (6) months following the date of injury;

- Care and treatment that is not according to accepted professional standards;

- Care and treatment that is not Medically Necessary;

- Services or supplies for the removal of corns or calluses, or trimming of toenails, treatment of chronic conditions of the foot such as week or fallen arches, flat or pronated metatarsalgia, or foot strain;

- Inpatient admissions primarily for diagnostic studies when inpatient bed care, if not Medically Necessary;

- Custodial care or rest cures, services provided by a rest home, a home for the aged, a nursing home or any similar facility;

- Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions, eyeglasses or contact lenses; and

- 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 Administrator and in no circumstances will such benefits exceed a maximum of six (6) consecutive months.

Hospital Pre-Admission and Continued Stay Review Program
For Active Employees and Dependents
Enrolled in the Fee-For-Service
Comprehensive Medical Expense
Benefits Plan
(Provided by First Health)

Note: For Treatment of a nervous or mental condition or substance abuse refer to page 39 for a description of the Member Assistance Program. The First Health program does not apply to these types of cases. Refer to page 55 for information of the timing of the benefit determinations.

Pre-Admission Review

Pre-Admission Review is a program designed to avoid unnecessary Hospitalizations. Through this review process you and your doctor will be advised if an inpatient Hospital stay is appropriate. If the review organization has a question as to the necessity of a Hospitalization, your doctor will be contacted and the problem will be solved.

How does the Program Work?

When your doctor recommends that you be confined in a Hospital, tell him to contact First Health at 800-559-8723 at least three (3) days prior to the planned admission to obtain Pre-Admission Certification for your Hospital confinement. If there is a question as to medical necessity or length of stay, a referral is made to a Physician Advisor who will work closely with your doctor to determine the appropriate treatment plan. The medical review is conducted without any effort on your part. **If you do not receive Pre-Admission Certification for your inpatient Hospital confinement, your benefit payments will be reduced by 50%.**

Pre-Admission Review is not necessary for persons enrolled in Medicare when this Plan is secondary payor or for Emergency Hospital admissions. However, Emergency Hospital confinement is subject to "Continued Stay Review."

Continued Stay Review

Once you have entered the Hospital (following the Pre-Admission Certification), First Health will continue to monitor your stay to determine the appropriate length of confinement and the necessity of x-ray, laboratory and other diagnostic and therapeutic services.

If the review organization feels your continued Hospitalization is unnecessary, you and your doctor will be notified.

Emergency Hospitalization

If you or one of your Dependents are admitted to a Hospital on an Emergency basis, your Physician, family member, or you should follow the procedure for continued stay review by contacting First Health, within seventy-two (72) hours of the admission. First Health will review your records to determine the necessity of your admission and the appropriate length of stay.

Preferred Provider Organization (PPO) Plan
For Active Employees and Dependents Enrolled in the
Fee-For-Service Comprehensive
Medical Expense Benefits Plan

As noted in the various descriptions contained in this booklet, if you or your Dependent(s) obtain services from a PPO doctor or Hospital, your out-of-pocket expenses will be less. PPO directories are available at no charge from the Fund Administrator or you can visit Southwest Administrator's website at www.swadmin.com and link to the First Health Network Provider Directory. Your password is (SDG). You may also call the First Health PPO Information Hotline at (800) 559-8723. Be sure to tell them you are covered by the Southern California Dairy Industry Security Fund.

What is the PPO Plan?

The Fund, through First Health, has contracted with many doctors and Hospitals who have agreed to provide services at reduced fees rather than at the usual and customary fee. This means that you and the Fund save money if you use a PPO provider.

How does the Program Work?

- When you need to see a doctor simply select one from the PPO provider listing. In many cases, you will be pleased to find that your current doctor has already agreed to participate in the PPO Plan. (Refer to the Schedule of Benefits on pages 26-27 for a comparison of the percentages paid between PPO and non-PPO providers)

- If you do not have the PPO listing of participating Hospitals and doctors, you may call First Health at 800-559-8723 for a participating Hospital or doctor in your area or visit Southwest Administrator's website at www.swadmin.com and link to First Health's Network Provider Directory. The password is SDG.

- When you visit the PPO doctor you have chosen, tell the receptionist that you are covered by the Southern California Dairy Industry Security Fund **AND** the First Health PPO Plan. If you are referred to a specialist or to a Hospital, remind your doctor that you want to use PPO doctors and/or Hospitals.

- Be sure to take your group health Plan identification card to your Physician's office. Your Physician will find it easier to verify your coverage when you are able to identify yourself as a First Health Network patient.

- You do not have to sign up with a particular doctor or medical group and use them exclusively for your medical needs. YOU MAY USE THE SERVICES OF ANY PPO DOCTOR AND/OR HOSPITAL WHENEVER YOU CHOOSE TO. However, for Mental Health and Substance Abuse treatment you must contact HMC/APS for referral authorization or no benefits will be paid.

Why Use the PPO Hospitals and Doctors?

- The Plan will pay a higher percentage of Covered Expenses. See the Schedule of Benefits on pages 26-27 for a comparison of the percentages paid between PPO providers and the non-PPO providers.

- PPO doctors have agreed to provide medical services to eligible Active Employees and their eligible Dependents at specified fees. This means that if you use a PPO doctor, you are assured that he/she will not bill you for the difference between the doctor's charges and what the Plan allows. A Non-PPO doctor may charge more for a particular service than what the Plan allows. If this is the case, you are responsible for payment of the entire amount of charges that exceed the Plan's Allowable Charge limit for the particular service performed.

Mental Health and Substance Abuse
(Member Assistance Program)
Utilization Review, Case Management and Quality Assurance Review Program for Active Employees and Dependents

Provided By Health Management Center, Inc. HMC/APS

What is the Member Assistance Program?

The Member Assistance Program is a mental health and substance abuse utilization review, case management, and quality assurance program that was instituted because of the increase in the Plan's costs for treating mental health and substance abuse related illnesses.

The purpose of the program is to coordinate care for mental health related problems, alcoholism and substance abuse. The program will administer pre-admission review, case management, and quality assurance review of all outpatient care and Hospitalizations for the treatment and diagnoses of mental health and nervous disorders or alcohol and substance abuse. Similar to the Hospital review program, this program is designed to ensure that mental health and substance abuse services are Medically Necessary, conform to professional standards, and are delivered in the most cost-effective manner possible.

What Is My Coverage?

If you are enrolled in the Fee-For-Service plan (indemnity) or United Healthcare, you and your eligible Dependent(s) will receive **both** mental health and substance abuse coverage under this program. If you are enrolled with Kaiser, you will receive both mental health and substance abuse coverage from Kaiser. Please call Kaiser Member Services at 800-464-4000 (English) or 800-788-0616 (Spanish).

How Does the Program Work?

If you or one of your Dependents need Hospitalization or outpatient treatment for a mental or nervous disorder or substance abuse, you must contact the Member Assistance Program prior to receiving treatment in order to receive maximum benefits. If you or your eligible Dependent(s) receive treatment without prior approval and referral of the Member Assistance Program, there will be no payment of benefits. The Member Assistance Program will arrange for counseling with an appropriate clinical specialist who is located near you, or if inpatient care is required, you will be referred to an approved facility. Benefits will only be paid for HMC/APS authorized services. In the event of an Emergency Hospitalization, maximum benefits will be paid only if you contact the Member Assistance Program within forty-eight (48) hours of the admission.

For assistance and information call: 1-800-431-5036. To access online Member Assistance Program services: Go to: APSWorklife.com. Enter username: scdairy. Enter password: worklife.

Refer to the Schedule of Benefits on page 40 for a summary of the services provided and your co-payments.

Schedule of Benefits for Mental Health and Substance Abuse Treatment

Mental Health	Benefit
Inpatient Care -	
Annual Benefit Maximum Days to be determined based on the following ratios:	50 days
Inpatient Treatment	1 day
Residential Treatment	50% of 1 day
Partial Day/Day Treatment	50% of 1 day
Acute/Urgent Care Treatment	1 day
Coinsurance Level	100% of contracted network facility's charges
Outpatient Care -	
Annual Benefit Maximum[4]	25 visits
Co-payment Individual Sessions (1-25)	$0 co-pay (If you exceed the annual visit maximum of 25 visits, you will be responsible to pay the full amount of the visit.
Coinsurance Level	100% of contracted network provider's charges
Chemical Dependency	
Inpatient/Outpatient Care -	
Outpatient Annual Benefit Maximum	25 visits
Inpatient Annual Benefit Maximum	10 days
Inpatient Lifetime Benefit Maximum	3 Episodes
Coinsurance Level	100% of contracted network facility's charges
Substance Abuse Professional (SAP) Service	100% of contracted network facility's charges

[4] One individual treatment session may be exchanged for two group sessions.

Prescription Drug Program
For All Active Employees and Dependents
Enrolled in Either the
Fee-For-Service or Prepaid Medical
Benefits Plans

(Provided through Medco Health)

The Fund has entered into an agreement with Medco Health, to provide prescription drugs to its members at discounted prices. Please contact the Fund Administrator for a listing of the Medco Health participating pharmacies or visit Southwest Administrator's website at www.swadmin.com and link to Medco Health's Network Retail Pharmacy locations.

When you and your Dependent(s) are eligible for the medical and hospital benefits provided by the Southern California Dairy Industry Security Fund, you are also eligible for the benefits of the Prescription Drug Plan.

Two options are available for obtaining prescription Drugs through the Medco Health program.

Benefit	Copayment
Walk-In Program – thirty (30) day supply;	
Generic.....	$5 co-payment
Preferred Brand Name.....	$10 co-payment
Non-Preferred Brand Name.....	$25 co-payment
Mail-Order Program – ninety (90) day supply; **Mandatory** for maintenance Drugs for the third refill and after	
Generic.....	$10 co-payment
Preferred Brand Name.....	$20 co-payment
Non-Preferred Brand Name.....	$35 co-payment

1. **Walk-In Program:** You may go to any Medco Health participating pharmacy and obtain your prescription by paying a co-payment for each prescription drug. A claim form is not necessary. Present your Medco prescription identification card identifying yourself as a member of the Southern California Dairy Industry Security Fund and, if you are eligible, the prescription will be provided to you at that time.

   THE ELIGIBLE DEPENDENT OF A MEMBER MUST KNOW THE MEMBER'S SOCIAL SECURITY NUMBER AND MEMBER ID NUMBER (WHICH IS ON YOUR PRESCRIPTION ID CARD) TO RECEIVE THIS BENEFIT. The Medco Health pharmacist is not permitted to reveal your Social Security Number. This is to protect you and the Fund from use of the Plan by unauthorized persons.

   If the pharmacist cannot determine your eligibility or has a question regarding your prescription, he will call the Fund Administrator for authorization. If this occurs after Fund business hours, you may have to return the next business day for your prescription.

If the prescription is required immediately, you may pay for the prescription and return to the Medco Health pharmacy for a refund after authorization has been obtained from the Fund.

Using the Medco Health Drug Plan, a thirty (30) day supply plus two refills are allowable, providing your doctor prescribed that amount. If you need an additional month of your prescription while you are on vacation, you will be required to pay the co-payment for each thirty (30) day supply. Remember: ***Drugs prescribed for more than ninety (90) days MUST BE obtained from the mail order program.***

PLEASE NOTE THAT THE CO-PAYMENT IS NOT REIMBURSED BY THE FUND AND IS SUBJECT TO CHANGE AT ANY TIME.

For those active Participants who live fifteen (15) miles or more from a Medco Health pharmacy, you may submit a claim to the Fund Administrator and be reimbursed up to 75% of the Covered Expenses for your prescription(s). A thirty (30) day supply plus two (2) refills are allowable. However, you **MUST** still utilize the mail order prescription drug program for the third refill and those thereafter for all maintenance medication. A ninety (90) day supply is allowable for all mail order maintenance prescriptions.

2. **Mail Order Program:** All Participants may utilize the mail order program. In addition, ***maintenance medications beginning with the third refill MUST be obtained through the mail order program.*** A form is available to be sent to Medco Health, along with the prescription form provided by your doctor. The mail order service will send the prescribed Drugs directly to you. You will usually receive your prescription within two (2) days. You may contact the Fund Administrator for this mail order form, or log onto Medco Health's website at www.medcohealth.com. Refill of mail order Drugs may also be ordered online from the Medco Health website: www.medcohealth.com.

   When your prescription is filled, you will receive a notice showing the number of times your prescription may be refilled, your prescription number, and a business reply envelope. Simply fill out the information on the reverse side of the business reply envelope, enclose the refill notice, seal, stamp, and mail. Your prescription will be refilled and mailed back to you.

IMPORTANT: A generic drug will be substituted for a brand name drug whenever available and allowed by your Physician.

If your Physician indicates "No Substitution" or "Dispense as Written" on the prescription form, the brand name drug will be dispensed to you with a brand name or non-preferred brand name co-payment. If **you** request that your prescription be filled with a brand name drug rather a generic drug, your co-payment will be the difference in cost between the brand and generic medication.

Many of the most prescribed Drugs are available under the generic names. Ask your doctor if the medication he/she is prescribing for you has a generic counterpart.

What are Generic Drugs?

A generic drug is identified by its official chemical name rather than a brand name. Because of existing patent laws, some medications are supplied only under their trademarked brand names. For example, St. Joseph's and Bayer are brand names for "aspirin" which is the generic name. They have the same active ingredients. They have the same effect on the body, and they meet the same Federal Government standards as their brand name equivalents.

You don't have to know the generic names of your prescription or how to pronounce it. Your doctor or pharmacist will know. All you have to do is ask your doctor if a generic drug is available and if so, to prescribe it instead of a higher priced brand name drug.

Many doctors just don't realize how much money you can save if they prescribe generic Drugs. Most doctors are not opposed to generics, and your doctor would probably like to help you save money. If so, the next time he/she prescribes medicine for you, ask him/her to prescribe generically, if possible.

If your doctor is unsure of a drug's generic name (this is common), ask him to add the phrase "or generic equivalent" to your prescription. This will help your pharmacist provide you with a more reasonable priced product.

What Drugs are Covered?

- Drugs which, under federal or state of California law, require the written or oral prescription from a Physician or Dentist.
- In addition, only the following items, which do not require a prescription by law, are covered if they are prescribed by a Physician or Dentist for a specific illness:

    - Insulin and diabetic supplies, including: insulin syringes, needles, disposable needles, sugar test tablets, sugar test tape, acetone test tables, Benedict's Solution or equivalent;

    - Compounded dermatological preparations: ointment and lotions which must be prepared by a Licensed Pharmacist in accordance with the prescription of a Physician;

    - Cough mixtures: Elixir Terpin Hydrate, N.F.;

    - Antacids: Aluminum Hydroxide, Aluminum Hydroxide with Magnesium Triscilicate, Aluminum and Magnesium Hydroxide Gel Calcium Carbonate, Magnesium Carbonate Suspension, and Dihydroxyaluminum Aminoacetate;

    - Eye and ear medication; or

    - Miscellaneous: Gamma Globulin, Epinephrine, USP, Ephedrine Sulfate

- 25 mg. (3/8 gr.), and Ferrous Sulfate, USP.

- Prescriptions dispensed by a Physician or Dentist in his/her own office which are otherwise covered under this program and for which a separate charge is made by the Physician or Dentist.

What is Not Covered?

- Prescription Drug Benefits are not payable for;
- Drugs purchased outside the U.S.A;
- Drugs taken or administered while you are in the Hospital;
- Medicines not requiring a prescription, except as noted above;
- Appliances, prosthetics, bandages, heat lamps, braces or splints;
- Contraceptives, except for birth control pills;
- Vitamins, cosmetics, dietary supplements, health and beauty aids, mother's milk or artificial blood;
- Injectable Drugs; (unless previously authorized);
- Any Drugs not reasonable necessary for the care or treatment of bodily injuries or sicknesses;
- Charges for prescription Drugs containing in excess of a thirty (30) day supply (ninety (90) day supply for maintenance Drugs);
- Smoking deterrents;
- Nose drops or other nasal preparations;
- Immunizations agents, biological, blood or blood plasma;
- Drugs necessary for sickness or accident covered by any Worker's Compensation or Occupational Disease Law;
- Non-drug items;

- Fertility medications;
- Drugs whose sole purpose is to promote or stimulate hair growth;
- Experimental or investigational Drugs; and
- Any number of Erectile Dysfunctional pills over the allowed six (6) Erectile Dysfunction pills per month when purchased through the walk-in-pharmacy or eighteen (18) Erectile Dysfunction pills per ninety (90) days when purchased through mail order.

General Limitations and Exclusions

(not applicable to Life Insurance, Supplemental Disability Benefits, the United Healthcare or Kaiser Medical Plans)

In addition to any exclusions listed in this booklet, the Plan will not provide benefits for:

- Any amounts in excess of Allowable Charges;
- Services not specifically listed as covered services;
- Any services, supplies or treatment of a condition for which the person is not under the care of a Physician, and which are not reasonably necessary for the care of bodily injury or sickness;
- Services for which the person is not legally obligated to pay, or for which no charge is made to the person;
- Work-related conditions if benefits are covered or can be recovered, either by adjudication, settlement or otherwise, under Workers' Compensation, Employer's Liability Law or Occupational Disease Law, even if the person does not claim those benefits;
- Conditions caused by an act of war, invasion, or nuclear explosion;
- Any bodily injury that is self-inflicted unless this injury results from a medical condition (including any physical or mental health condition) whether or not such medical condition had been diagnosed before the accident, or that results from the covered person's commission of a crime (including but not limited to driving under influence). However, benefits are payable for bodily injuries incurred during the commission of crimes where the covered person was a victim of domestic violence or where the crimes were committed as a result of a physical or mental condition;
- Any services provided by a local, state or federal government agency (except as required by Federal law), or services for which payment may be obtained from a local, state or federal government agency (except Medi-Cal);
- Experimental treatment. For purpose of this exclusion, experimental treatment shall be that medical treatment which the state's medical association does not endorse as a recognized procedure of medical significance or therapeutic value and/or any course of treatment making use of devices or Drugs not yet approved by the Federal Drug Administration; and
- Care and treatment that is **not** Medically Necessary.

Vision Care Benefits
(Provided by Vision Service Plan)

The Vision benefits in this section are self-funded and provided through an administrative services contract with Vision Service Plan (VSP).

Schedule of Vision Benefits	
	Co-payment/Frequency
Examinations	$5 per Participant
Frequency of Services -	
Examinations	Once every twelve (12) months
Lenses (single vision, bifocals, trifocals, lenticular)	One pair every twelve (12) months, only if needed
Frames	One set every twelve-four (24) months, only if needed . Covered up to $120.00
Contact Lenses	Once every twelve (12) months
Medically Necessary	$5 co-pay for one year supply every twelve (12) months (in lieu of all other benefits). Authorization required.
Elective	$105 allowance for contacts and the contact lens exam (fitting and evaluation) every twelve (12) months, twenty-four (24) month wait for frames thereafter.

Vision Benefits

The Vision plan provides the following benefits to eligible Active Employees and their qualified Dependents up to the maximums specified, when services are rendered by VSP Member Doctors:

1. *Vision Examinations* – A complete analysis of the eyes and related structures to determine the presence of vision problems, or other abnormalities. Available every twelve (12) months.

2. *Lenses* – The VSP Doctor will order the proper lenses (only if needed). The program provides the finest quality lenses fabricated to exacting standards. The Doctor also verifies the accuracy of the finished lenses. Available every twelve (12) months, only if needed.

3. *Frames* – The allowance for frames under this Plan is $120.00. If you select a frame that costs more than the allowance you will receive a 20% discount on the overage. Available every twenty-four (24) months, only if needed.

4. *Contact Lenses* – Medically Necessary contact lenses are furnished under the Plan when the VSP Doctor secures prior approval for the following conditions:

    a. Following cataract surgery;
    b. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
    c. Certain conditions of anisometropia; or
    d. Keratoconus

When your Doctor receives approval for such cases, costs are covered in full by VSP, in lieu of all other material benefits – including spectacle lenses and frames.

Elective Contact Lenses: Patients may choose contact lenses in lieu of frames and lenses. Under this Plan there is an allowance of $105 for contacts. This allowance applies to the cost of the contact lens exam and contacts. You will also receive a 15% discount off the doctor's professional fees.

Costs of Benefits

When you select a Doctor from the VSP list, this Plan covers the visual care described herein (examination, professional services, lenses, frames) at no cost to you other than a $5 co-payment for examinations. Co-payments are payable to the VSP Doctor at the time of the examination. Any additional care, service and/or cosmetic options/materials not covered by this Plan may be arranged between you and your Doctor.

How to Use the Plan

- Obtain a brochure from the Fund Administrator.

- Call a VSP Doctor to make an appointment. Advise them that you are a VSP member. To locate a VSP doctor simply visit VSP's website at www.vsp.com or call VSP's Member Services at (800) 877-7195.

- The VSP Doctor and VSP will handle the rest by verifying your eligibility and Plan benefits.

- The VSP Doctor will perform the exam and, if necessary, prescribe and order materials.

- Pay co-payment amount for covered services and any out-of-pocket expenses (if any) for optional and/or cosmetic options not covered by the Plan.

- VSP will pay the Doctor directly for covered services – no further paperwork is required of you.

How to Submit a Non-VSP Doctor Claim

- When using an out-of-network provider you will be required to pay the provider in full at the time of service.

- To receive reimbursement, submit to VSP an itemized copy of the bill(s) from the non-VSP Doctor, along with your name, address, phone number, covered members ID number and the name of the organization your VSP coverage is through. Forward the information to:

Vision Service Plan
Attn: Out-of-Network Provider Claims
P.O. Box 997105
Sacramento, CA 95899-7105

- Claims must be submitted within six (6) months from the date of service. Please be aware that there is no guarantee that the reimbursement will be sufficient to cover the total cost of all charges.

Customer Service

Customer service is available 24-hours a day by calling 1-800-877-7195. The website also provides Plan information and describes your personal benefits at: www.vsp.com.

Claims Information

Coordination of Benefits

Members of a family are often covered by more than one group health plan. As a result, two (2) or more plans will often cover the same expense. To avoid costly duplication of benefit payments, your health Plan provides a Coordination of Benefits provision. This provision affects all your health coverage, including those described in separate booklets or inserts.

How Coordination Works

If you or your Dependents are also covered under another group plan, the total amount received from all plans will never be more than 100% of allowable expenses. Benefits are reduced only to the extent necessary to prevent any person from making a profit on his or her coverage.

Allowable expenses are any necessary and reasonable expenses for medical or dental services, treatment or supplies covered by one of the plans under which you or your Dependents are insured.

A plan is considered to be any group plan providing coverage for medical treatment or services on an insured basis. This includes group blanket or franchise insurance, group Blue Cross, group Blue Shield, group practice and any other group prepayment coverage, labor-management trustee plans, Union welfare plans, employer organizations plans, any coverage under governmental programs and any coverage required or provided by law, including mandatory state no-fault auto insurance.

This Coordination of Benefits provision shall not apply to any other coverage for which you pay the entire premium.

Which Plan Pays First

If one plan does not have a Coordination of Benefits provision, that plan always pays its benefits first (and is known as the primary).

If both plans have a Coordination of Benefits provision, the plan that insures you as an Employee pays first. If you are insured as an Employee under two plans, the plan which has insured you longer is primary. However, if you are insured as an active employee under one plan and as a laid-off employee or retired employee under another plan, the plan that insures you as an active employee will pay its benefits first – this does not apply if neither plan has provision regarding laid-off or retired employees.

If a Dependent child is covered under two plans, the plan of the parent whose birthday occurs earliest in the calendar year pays its benefits first. If both parents have the same birthday, the plan which has covered the Dependent child for the longer period pays its benefits first. If the parents of a Dependent child are divorced or separated, the plan of the parent with custody is the primary. If the parent with custody re-marries, the "order of payment" is as follows:

The natural parent with whom the child resides;

- The stepparent with whom the child resides; and
- The natural parent not having custody of the child.
- This order of payment can change if the divorce decree directs one of the parents to be financially responsible for the health care expenses of the child.

Right to Obtain or Release Information

The Fund may obtain or release any information necessary to implement these provisions.

You must declare your coverage under other plans. The Fund can pay to another paying organization amounts warranted to satisfy the intent of this provision, and to the extent such payment is discharged from liability for that claim. The Fund can also recover from the insured, from another insurance company, or from another organization, amounts that are overpaid under this provision.

Information necessary for the administration of this provision will be required of you at the time a claim is submitted.

Medicare

Unless you elect otherwise, this Plan will provide primary coverage for you and your eligible Dependents if you are an Active Employee age 65 or over and eligible for Medicare.

If you are a disabled Dependent of an Active employee and eligible for Medicare because of total and permanent disability, this Plan will continue to provide primary coverage at age 65. If you are an Active Employee and eligible for Medicare because of total and permanent disability, or the disabled Dependent of an Active Participant, this Plan will continue to provide primary coverage at age 65.

If you are an Active Employee or Dependent and are eligible for Medicare because you have end stage renal disease, this Plan will continue to provide primary coverage for the first 30 months of your eligibility for Medicare.

If you are a retired employee under another plan, or the spouse of a Retired Employee, Medicare will provide your primary coverage. Benefits will be coordinated with Medicare, as if Medicare had been primary and as if Participants are covered by both Medicare Part A and Part B.

THIRD PARTY RESPONSIBILITY – EQUITABLE LIEN AND SUBROGATION AGREEMENT

In case of an injury or illness which may have been caused to you by the act or omission of a third person, you must complete the Fund's Injury or Illness Questionnaire ("Questionnaire") and the Fund's Acknowledgement of Equitable Lien and Subrogation Agreement ("Agreement"). The Agreement provides that you recognize the Fund's equitable lien on any money you recover from a third party (whether by settlement or judgment or otherwise) on account of that injury or illness ("Recovery"). The dollar amount of this equitable lien is the dollar amount of benefits that are owed or paid to you by the Fund on account of that injury or illness. (See below for further details). The Agreement also provides that you separately recognize the Fund's right of subrogation with respect to any legal right you have against such third party, again in the amount of the benefits owed or paid to you by the Fund. If any dependents were so injured or became ill, each of them must also sign the Agreement. A parent or guardian may sign for a minor dependent. Completion of the Questionnaire and the Agreement is a condition of eligibility for Fund benefits for you and your affected dependents, so failure to do so will result in nonpayment of any benefits. Breach of the Agreement will also result in nonpayment of any benefits. You and your affected dependents will also be required to furnish the Fund with periodic reports of the status of any and all claims against any such third party.

The Fund has an equitable lien on any Recovery by you or your affected dependents in the amount of benefits that all or any of you are owed or received from the Fund. The Fund is also subrogated to your (or your dependent's) right to recover money damages from such third party, up to the amount of benefits owed or paid to you and them by the Fund. The dollar amount of the equitable lien and the dollar amount of the subrogation rights of the Fund shall not be reduced (1) even if you and your dependents have not been made whole or have not received the full damages claimed, and (2) by any attorney's fees you and your dependents had to pay to pursue your claims against such third party. The Fund retains the right, however, for good cause shown, to agree to credit you and your dependents for all or part of their attorney's fees; any agreement to do so must be in writing to be valid. Notwithstanding any other provision in this Summary Plan Description, the Fund's lien and subrogation rights shall arise when the Fund becomes obligated to pay your claim or the claim of any dependent, not when the claim is paid.

This provision shall not be interpreted as conferring any benefit not specifically conferred elsewhere in the Plan.

Workers' Compensation

This Plan does not provide coverage for work-related disabilities. However, if payment is provided for such services, the Fund shall be entitled to establish a lien upon such benefits up to the amount paid for the treatment of the injury or disease which was the basis of the person's claim under workers' compensation law, occupational disease law, or similar legislation. The Participant shall cooperate with the Fund to ensure the Fund's lien rights are adequately protected.

Claims and Appeals Procedures

The procedure for filing claims and appeals for the fee-for-service Medical is described in the following pages.

- If you are enrolled in one of the HMO Plans, please refer to the booklet or Evidence of Coverage (EOC) provided by your HMO for information on the HMO's claims and appeals procedures.

- If you are enrolled in the Indemnity Dental plan of the Joint Council of Teamsters No. 42 Welfare Trust Fund, please refer to its summary plan description for the claims and appeals procedures.

- If you are enrolled in one of the prepaid Dental plans, please refer to the provider brochure for the claims and appeals procedures.

- For the vision plan, please refer to the provider brochure for the claims and appeals procedures.

- For Life Insurance claims and appeals, please refer to the ULLICO Certificate of Group Insurance.

The Plan's claims procedures include administrative safeguards and processes designed to ensure and to verify that benefit claims determinations are made in accordance with governing Plan documents.

How to File Claims

Time of Notice

You must send written notice of a self-funded fee-for-service medical or dental claim to the Fund Administrator within ninety (90) days after an expense or loss occurs. If you cannot send notice within that time, you must send it as soon as reasonably possible.

Submit your self-funded fee-for-service Medical notice of a claim to the Fund Administrator. A claim will be considered to have been filed as soon as it is received at the Fund Administrator's office, provided it is complete, with all necessary documentation required by the notice of claim. If the notice is not complete, you or your authorized representative will be notified of the additional evidence required to establish whether or not a claim should be paid. The Fund Administrator may, for example, request supplementary documentation or the results of a physical examination or laboratory test in order to adjudicate a medical claim.

This notification will be provided to you or your authorized representative as soon as reasonably possible, but not later than five (5) days for a pre-service claim or 24 hours for an urgent care claim. For an urgent care claim, the notice may be provided to you or your representative orally, unless you or your representative requests a written notice.

If you fail to cooperate with such requests, your claim may be denied.
If your claim is denied, in whole or in part, a notice of an adverse benefit determination will be sent to you or your representative.

"Adverse benefit determination," as used in this booklet, is defined as a denial, reduction, or termination of benefit, including the failure to pay a benefit due to the application of any utilization review, ineligibility, or a determination that it is experimental, not Medically Necessary, or appropriate.

Forms

When the Fund Administrator receives the notice of claim, they will send a claim form to you for filing proof of loss. If the Fund Administrator does not send the claim form within fifteen (15) days, you will be deemed to comply with the proof of loss requirements by sending written proof of loss as set forth below. Written proof must be submitted:

- To the Fund Administrator; and
- Within ninety (90) days after the end of each period for which the benefits are to be paid.

Claims should be filed ninety (90) days after you incur the medical expense. Claims will still be considered for payment when it is not possible to provide notification within ninety (90) days, but you should always file your claims as soon as possible.

Claims will not be paid if they are submitted more than twelve (12) months after the expense was incurred, except in the absence of legal capacity.

Proof of Loss

In case of a health claim for expense or loss for which a periodic benefit is paid while the loss continues, you must send written proof of loss:

- To the Fund Administrator; and
- Within ninety (90) days after the end of each period for which the benefits are to be paid.

In the case of a health claim for any other expense or loss, you must send written proof of loss to the Administrator within ninety (90) days after the date expense or loss is incurred. The Fund Administrator will not deny or reduce a claim due to the fact that you are not able to send the proof of loss within ninety (90) days, but for the lack of legal capacity. However, in no case will claims be honored more than one year after the date of service.

Benefit Determinations

Claims for benefits under the Plan will be processed, and benefit determinations will be made, within the time frames allowed under the regulations depending on the type of claim submitted. There are four types of claims that may be filed under this Plan. A description of these claims and the Benefit determination time period are as follows:

1. Urgent Care Claim – any claim for medical care or treatment that must be determined promptly to avoid jeopardizing your life, health or ability to regain maximum function, or in the opinion of the attending Physician could subject you to severe pain if care or treatment is not received. If you require urgent care, you should seek immediate medical attention.

2. Pre-Service Claim – any claim for a benefit that requires you to obtain approval before you receive medical care or treatment. This includes any prior authorization before you see a specialist or non-PPO provider, before any Hospitalization, or to obtain a higher benefit payment for an item or service.

   You will be notified by the Plan of the benefit determination (whether adverse or not) not later than fifteen (15) days after receipt of your claim by the Plan.

3. Post-Service Claim – any claim for medical care or treatment that you have already received.

   You will be notified of an adverse benefit determination no later than thirty (30) days after receipt of your claim by the Plan.

4. Concurrent Care Claim – any claim that results from the termination or reduction of previously granted benefits to be provided over a period of time. The Plan will notify you in advance of the termination or reduction to allow you time to appeal the decision and obtain a determination before the benefit is reduced or terminated.

Any request to extend a course of treatment is governed by the standards generally applicable to such claims.

5. Total Disability – any claim for extension of benefits resulting from Total Disability (the inability of a person to engage in any business, occupation, or employment for remuneration, profit or gain). You will be notified of the decision (whether adverse or not) not later than:

   - Forty-Five (45) days from the receipt of your claim form, doctor's certification, copy of State Disability Insurance (SDI) or Worker's Compensation check stub certifying to the dates of disability; or

   - Within an additional thirty (30) days if sufficient information has not been received and, therefore, a decision is not possible and is beyond the control of the Fund Administrator; or

   - Within additional thirty (30) days after the first thirty (30) day extension if a decision has not been made because it is beyond the control of the Fund Administrator.

Notice will be given to you of each extension and the reasons thereof before the end of the first forty-five (45) days and again before the end of the first thirty (30) day extension and before the end of the last thirty (30) day extension.

To Whom Benefits Are Payable

Any health benefits payable for loss of your life will be paid to your designated beneficiary. Except as set forth below, any other benefits that have not been paid when you die may be paid either to your beneficiary or to your estate, at the option of the Fund Administrator. All other amounts will be paid to you.

Benefits Unpaid at Death – Incompetence

Benefits may be payable to any person or institution entitled to such payment, as much as $500 of any benefits, that:

- Are to be paid at the time of your death; or

- Are to be paid to a minor who is not able to execute a valid release, and for whom no guardian has been appointed.

To the extent of the payment, the Fund Administrator will have no more liability under the group Plan.

Physical Examination and Autopsy

The Fund Administrator shall have the right and opportunity to order the examination of a Participant by a Physician of its choice, to determine the extent of any sickness or injury for which a claim is made. This right may be used as often as it is reasonable to do so. If a

Participant dies, an autopsy may be required (where the law does not forbid it). Such an examination or autopsy shall be made at the expense of the Administrator.

Extensions for Pre-Service And Post-Service Claims

The initial determination of benefits will be made as soon as possible, but not later than the period of time indicated above after the Plan receives your claim. The initial benefit determination period may be extended as follows:

1. Pre-Service Claim – the initial fifteen (15) days benefit determination period may be extended up to an additional fifteen (15) days if special circumstances beyond the control of the Plan require an extension of time to process the claim. If such an extension is required, you will be sent a written notice before the expiration of the initial fifteen (15) day period, stating the special circumstances requiring the extension and the date a decision on the claim can be expected.

2. Post-Service Claim – the initial thirty (30) day benefit determination period may be extended up to an additional fifteen (15) days if special circumstances beyond the control of the Plan require an extension of time to process the claim. If such an extension is required, you will be sent a written notice before the expiration of the initial thirty (30) day period, stating the special circumstances requiring the extension and the date a decision on the claim can be expected.

Incomplete Claims

If you fail to follow the filing procedures or do not provide sufficient information for a pre-service or post-service disability claim, you will be given at least forty-five (45) days to perfect your claim or provide any requested information. The time period for making a decision will be suspended from the date of the notification to the earlier of: (1) the date on which a response is received by the Plan, or (2) the date established by the Plan for furnishing the requested information (at least forty-five (45) days).

Notice of Claim Denial

If the Plan makes an adverse benefit determination, in whole or in part, you will be notified in writing of the determination and will be given the opportunity for a full and fair review of the benefit decision. The written notice of denial will include:

1. the specific reason or reasons for the denial;

2. reference to specific Plan provisions on which the denial is based;

3. a description of any additional material or information necessary for you to perfect your claim and an explanation of why that material is necessary;

4. a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim; these relevant documents include any information that was

relied upon, submitted, considered or generated in the course of making the benefit decision;

5. if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request;

6. if a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the adverse determination, you will be provided with a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided to you free of charge upon request; and

7. a description of the Plan's appeal procedures including a statement of your rights to bring a civil action under section 502 (a) of ERISA following an adverse determination on review, but only after you first exhaust the claims and appeals procedures as set firth herein.

Appeals Procedures

If you apply for benefits and your claim is denied, or if you believe you did not receive the full amount of benefits to which you are entitled, you have the right to petition the Plan for a review of the denial of your claim.

The petition must be in writing, state the reason or reasons for disputing the denial and must be accompanied by any pertinent material not already furnished to the Plan. You or your authorized representative must file the appeal with the Plan within one hundred eighty (180) days after you receive the notice of claim denial.

The Plan will review all submitted comments, documents, records and other information related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination. The Plan will not give deference to the initial adverse benefit determination.

If the adverse benefit determination is based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment. The health care professional will be an individual who is neither the individual consulted in connection with the initial benefit determination nor the subordinate of such individual. The Plan will provide you with the identification of any medical or vocational expert whose advice was obtained in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

Appeals Determination Time Period

The time period for a benefit determination on review will begin at the time an appeal is filed under the Plan as instructed above, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. You must, therefore, make sure that your claims appeal is complete and any documentation or evidence is included with your claims when you file your appeal. You will be notified of the decision of the Plan in writing as follows:

1. Pre-Service Claim – You will be notified of the benefit determination not later than thirty (30) days after receipt by the Plan of your request for review of an adverse benefit determination.

2. Post-Service Claim* - A properly filed appeal will be reviewed by the Board of Trustees at its next regularly scheduled meeting. However, if the appeal is received within thirty (30) days prior to the meeting, the appeal may be reviewed at the second meeting following receipt of your appeal.

   If special circumstances beyond the control of the Plan (such as the need to hold a hearing) require an extension of time, the Board of Trustees will render a decision at the third scheduled Board meeting following receipt of the appeal. The Plan will provide you, prior to the start of the extension, with a written notice of the extension describing the special circumstances and the date that the Board of Trustees will make its decision. A written notice of the decision on an appeal will be provided to you within five (5) calendar days following the Board of Trustees meeting.

   *In the event that you want or need additional time to present evidence in support of your petition for review, you may request such additional time in writing. The Trustees will grant your written request for additional time necessary to perfect a petition for review, provided the written request is received before the Trustees issue their decision. Requests for additional time and requests to submit additional information received after the Trustees' decision has been rendered will be denied, unless the Trustees, in their sole discretion, determine that the information is material to the petition and could not have been provided earlier.

3. Disability Claims – You will be notified if a claim is wholly or partially denied within forty-five (45) days of the date of receipt of the claims. You will have up to one hundred eighty (180) days from the receipt of the notice of denial to appeal the decision.

   You will receive a response within forty-five (45) days from the date the appeal is received. This period may be extended for up to an additional forty-five (45) days if additional information is required and you will be notified for the special circumstances and the date that the Plan expects to render the benefit determination.

In the case of an adverse benefit determination on the appeal, the written denial will indicate:

1. The specific reasons for the denial;

2. Reference to the pertinent Plan provisions on which the denial is based;

3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;

4. A statement of your right to bring a civil action under section 502 (a) of ERISA;

5. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request; and

6. If a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the adverse determination, you will be provided with a statement that the explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request.

The failure to file an appeal within the one hundred eighty (180)-day period from the initial denial of your claim will constitute a waiver of your right to a review of the denial of your claim.

If you are not satisfied with the decision made on your appeal, you may file a lawsuit in federal court against the Plan. However, you must complete the appeal to the Trustees before you may file a lawsuit. You will waive your rights to file a lawsuit against the Trust, unless you do so within 24 months after you complete the appeals process and the Fund denies your claim.

Special Notes

Claims and Appeal Procedures for HMO Plans, prepaid Dental Plans, Prescription Drugs, Vision Plan and Life Benefits:

If the benefits involved are provided by an insurance company, insurance service, health maintenance organization, or other similar organization, that organization may be entitled to conduct the review and make the decision. Disputes concerning benefits provided by one of the HMO's, prepaid Dental or ULLICO for the Life benefits generally must be resolved using the appeal procedures established by that organization. See the applicable booklet or Evidence of Coverage (EOC) for details of the organization's claims and appeals procedures.

Authorizing a Representative

The claims and appeals procedures outlined above do not preclude your authorized representative from acting on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination. In order to determine if an individual or firm has been duly designated by you, a form authorizing such entity to act as your representative must be completed and received

by the Plan. However, if a claim involves urgent care, the Plan will permit a health care professional with knowledge of your medical condition (i.e., a Treating Physician) to act as your authorized representative.

General Provisions

These general provisions apply to all benefits under the group Plan.

Assignment

You may assign the benefits under the group Plan to be paid for a medical charge. No other assignment of the group Plan or any rights or benefits under the Plan will have any force or effect unless and until the Fund Administrator consents to it in writing.

Incorrect Reporting

The facts shall be used to determine to what extent, if at all, a Participant is or was insured under the group Plan when:

- Any information that pertains to the Participant is found to have been reported incorrectly to the Fund Administrator; and
- The error affects the existence or amount of coverage.

Depending on the facts and circumstances, the Trustees may suspend the payment of benefits to a participant or a beneficiary or withhold and offset such benefits for claims incurred on behalf of any particular or beneficiary who owes money to the Trust.

Exemptions

To the full extent the law permits, all rights and benefits that accrue under the group Plan shall be exempt from execution, attachment, or other legal process for the debts or liabilities of any Participant or beneficiary.

Workers' Compensation

The group Plan is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation insurance.

Statements Not Warranties

All statements made by the Participant will, in the absence of fraud, be deemed representations and not warranties. No statement made by Participant to obtain coverage will be used to avoid or reduce the coverage, unless made in writing and signed by the Participant with a copy sent to the Participant.

Fund Reimbursement

In addition to the specific circumstances set forth elsewhere in this document in which the Trustees may suspend the payment of the benefits to a participant or a beneficiary, the Trustees

shall also have the general power to withhold and offset such benefits for claims incurred on behalf of any participant or beneficiary who: (1) owes money to the Fund because of any obligations imposed upon them by this Plan booklet, the rules and regulations of the Fund, or (2) owes money to the Fund because the Fund overpaid a participant or beneficiary, (3) or in any other circumstance in which a participant or beneficiary legally owes money to the Trust.

The Trustees also reserve the right to refuse payment for services rendered or facilities or supplies furnished by particular health care providers. These powers may be used as the Trustees deem necessary.

The Trustees must ensure that all who benefit from the Plan do so appropriately, and only as they are entitled. For example, if the Trustees determine that a Participant, his Dependents, or health care provider has committed any fraud or made any intentional misrepresentation in connection with claims for benefits or has committed any act or omission resulting in abuse or misuse of the Plan, the Board of Trustees reserves the right and authority to impose upon Participants and their Dependents restrictions with respect to their future rights to receive benefits from the Trust. The Trustees reserve the right to, seek reimbursement and other damages, together with attorney's fees (to the extent provided by law) and other costs incurred in connection with recovering any benefits incorrectly paid, or not reimbursed when reimbursement is required under the Plan. To be reimbursed for benefits improperly paid, the Trustees may also exercise a right of offset against future benefits payable on behalf of the Participant and his Dependents. The Trustees also reserve the right to refuse payment for services rendered or facilities or supplies furnished by particular health care providers. These powers may be used as the Trustees deem necessary.

Definitions

"Active Employees" means any person who, by reason of their active employment, meets the eligibility requirements hereunder as established by the Plan as amended from time to time.

"Allowable Charge" means a charge which falls within the common range of fees billed by a majority of providers for a procedure in a given geographic region, or which is determined by the Board of Trustees and revised from time to time. "Allowable Charge" means the percentage of the Medical Data Research (MDR) payment system approved by the Board of Trustees from time to time. Allowable Charges for these procedures may not represent the common range of fees billed by a majority of providers.

"Alternate Recipient" means a child of an Active Employee who is eligible for benefits from the Fund as a Dependent pursuant to the provisions of a Qualified Medical Child Support Order.

"Board of Trustees" and **"Board"** means the Board of Trustees established by the Trust Agreement.

"Contract Hospital" means each Hospital bound to a written agreement with the Fund concerning the provision of health care services to Eligible Individuals of the Fund.

"Contributing Employer" means any employer who is required by a Collective Bargaining Agreement with a Union or is otherwise obligated to make contributions to the Fund. The term "Contributing Employer" shall also include the Union if it makes contributions to the Fund on behalf of its employees.

"Covered Expenses" means charges for services and supplies which are deemed Medically Necessary and are considered for payment by the Plan. These charges are subject to Allowable Charges definition.

"Dependent(s)" means:

1. The Active Employee's lawful spouse;

2. The Active Employee's married children, from birth to age 26, including stepchildren and adopted children.

3. The Active Employee's unmarried child(ren) older than 26 years of age who is prevented from earning a living because of a mental of physical disability, provided such disabled child(ren) was also disabled and covered as a Dependent prior to age 26 and remains primarily dependent upon the Active Employee for support. The Fund Administrator requires proof of continuing disability in a form and frequency established by the Board of Trustees.

   The term "Dependent" also includes the qualified Domestic Partner (but not the dependent children of the Domestic Partner) of the Active Employee.

"Dentist" means a Dentist licensed to practice Dentistry in the state in which he/she renders treatment.

"Domestic Partner" means a person over the age of 18 who is the same-sex as the Active Employee or, if the opposite sex of the Active Employee provided either the Active Employee or the Domestic Partner is age 62 or older and eligible for benefits under the Title XVI of the Social Security Act. In either case, the Active Employee must complete enrollment forms and provide a copy of a valid Declaration of Domestic Partnership filed with the Secretary State.

"Drugs" means any article which may be lawfully dispensed, as provided under the Federal Food, Drug, and Cosmetic Act including any amendments thereto, only upon a written or oral prescription of a Physician or Dentist licensed by law to administer it.

"Effective" or **"Effectiveness"** means that the Intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

"Emergency" means the sudden onset of a condition requiring immediate treatment, including but not limited to, a heart attack, poisoning, loss of consciousness, or convulsions.

"Episode" is a course of treatment or program undertaken for Chemical Dependency or Substance Abuse. Each course of treatment will count as one (1) Episode if the participant resumes interrupted treatment within 60 days of leaving treatment. If the return to treatment requires return to a higher level of care, this would be a second Episode. An "Episode" can mean hospitalization, partial hospitalization, and outpatient (in conjunction with such hospitalization and partial hospitalization).

"Essential Health Benefits" include: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavior health treatment; prescription drugs, rehabilitative and habilitative services and devices; laboratory services and devices; preventive and wellness services and chronic disease management, and pediatric services, including dental care and vision care. Regulations are yet to be issued describing in further detail what is meant by each of these Essential Health Benefits.

"Fund" means the Southern California Dairy Industry Security Fund established by the Trust Agreement.

"Fund Administrator" means Southwest Administrators, Incorporated, the third party administrator contracted with to handle the day to day operations of the Fund.

A **"Health Intervention"** is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury; genetic or congenital defect; Pregnancy; or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation or to maintain or restore functional ability). For the contractual definition of "Medical Necessity," a Health Intervention is defined not only by the Intervention itself, but also by the medical condition and patient indications for which it is being applied.

"Health Outcomes" are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

"Home Health Agency" as used under the fee-for-service benefit descriptions means a home health care provider which is licensed according to state or local laws to provide skilled nursing and other services on a visiting basis in the person's home, and must be recognized as a provider under Medicare, 42 U.S.C. § 1395x(o).

"Hospice Facility" as used under the fee-for service benefit descriptions means a facility or designated part of a Hospital which meets the requirements for participating as a "Hospice Facility" under Medicare, 42 U.S.D. § 1395x (dd).

An approved Hospice Facility may include any of the following:

1. Inpatient Care:
    a. Acute care Hospital with centralized palliative care or a hospice unit;
    b. Acute care Hospital team that visits patients; and
    c. Units operated as part of a Health Maintenance Organizations;
2. Free-standing Hospital-affiliated Hospice;
3. In-home care program:
    a. Hospital based;
    b. Nursing-home based; and
    c. Community-based.

"Hospital" as used under the fee-for-service benefit descriptions means an institution legally operating as a Hospital, which is:

1. primarily engaged in providing, for compensation from its patients, inpatient medical and surgical facilities for diagnosis and treatment of sickness or injury or the care of Pregnancy; and
2. operated under the supervision of a staff of Physicians and continuously provides nursing services by registered graduate nurses for twenty-four hours of every day.

In no event, however, shall such term include any institution which is operated principally as a rest, nursing or convalescent home or for the care and treatment of drug addicts or alcoholics, or any institution or part thereof which is primarily devoted to the care of the aged or any institution engaged in the schooling of its patients.

An **"Intervention"** is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

- An Intervention is considered **"Cost Effective"** if the benefits and costs represent an economically efficient use of resources for a patient with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

- **"New Interventions"** for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.

- For **"Existing Interventions"**, the Scientific Evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of medically necessity. If no Scientific Evidence is available, professional standards of care should be considered.

If professional standards of care do not exists, or are outdated or contradictory, decisions about Existing Interventions should be based on expert opinion. Giving priority to Scientific Evidence does not mean that coverage of Existing Interventions should be denied in the absence of conclusive Scientific Evidence. Existing Interventions can meet the contractual definition of medical necessity in the absence of Scientific Evidence if there is a strong conviction of Effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards of care or, in the absence of such standards, convincing expert opinion.

For Benefit Determination an Intervention will be covered if it is an otherwise covered category of service, not specifically excluded, and Medically Necessary.

- Authority
  An Intervention is Medically Necessary if, as recommended by the Treating Physician and determined by the health Plan's medical director or Physician Designee, it is all of the following:

- Purpose
  A Health Intervention for the purpose of treating a medical condition:

- Scope
  The most appropriate supply or level of service, considering potential benefits and harms to the patient:

- Evidence
  Known to be Effective in improving Health Outcomes. For New Interventions, Effectiveness is determined by Scientific Evidence. For Existing Interventions, Effectiveness is determined first by Scientific Evidence, then by professional standards, then by expert opinion; and

- Value
  Cost-effective for this condition compared to alternative Interventions, including no Intervention. "Cost-effective" does not necessarily mean lowest price.

An Intervention may be medically indicated, yet not be a covered benefit or meet this contractual definition of Medical Necessity.

"Licensed Pharmacist" means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

"Medically Necessary" means an Intervention is Medically Necessary if, as recommended by the Treating Physician and determined by the health Plan's medical director, it is all of the following: A Health Intervention for the purpose of treating a medical condition; the most appropriate supply or level of service, considering potential benefits and harms to the patient; known to be Effective in improving Health Outcomes. For New Intervention, Effectiveness is determined by Scientific Evidence. For Existing Interventions, Effectiveness is determined by first by Scientific Evidence, then by professional standards, then by expert opinion: and Cost Effective for this condition compared to alternative Interventions, including no Intervention. "Cost Effective" does not necessarily mean the lowest price.

"Medicare" means the program established under Title 42, Chapter 7, Subchapter XVIII of the Social Security Act (Federal Health Insurance for the Aged and Disabled), 42 U.S.C. § 1395 et seq.

Mental Health Treatment: Services and supplies furnished to diagnose or treat a mental, nervous, psychiatric or emotional disorder or condition.

Non-Contracting Provider: A Hospital, doctor, laboratory, etc. with whom the Fund has no contract to provide services at a savings to the Fund and Participants. Use of such providers will cost the Participants more money as co-payments and out-of-pocket expenses will be larger.

"Participant: means any Active Employee, his dependent or a COBRA eligible person when covered under the Fund.

"Plan" means the Southern California Dairy Industry Security Fund established by the Trust Agreement.

"Physician" as used under the fee-for-service benefit descriptions means a licensed Doctor of Medicine or Doctor of Osteopathy. Physician shall also include a Psychologist, Podiatrist, or Chiropractor, who renders care or treatment within the limits set forth in the license issued to him/her by the agreeable agency of the state in which he/she renders such care or treatment.

The term "Physician" will not include any person who is the spouse, child, brother, sister or parent of the Active Employee or the Active Employee's Spouse.

"Physician Designee" means a Physician designed to assist in the decision-making process.

Pregnancy: Any Pregnancy, a complication thereof, or the termination of a Pregnancy.

"Qualified Medical Child Support Order (QMCSO)" means an order providing for benefit payments to an Alternate Recipient which meets all of the requirements of the Employee Retirement Income Security Act of 1974 (ERISA) as amended by the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) or thereafter, including approval as a qualified order by

the Fund. You may obtain, without a charge, a copy of the Plan's QMCSO procedures from the Fund Administrator.

"Registered Nurse" as used under the fee-for-service benefit descriptions means a Registered Nurse, who does not ordinarily reside in the Active Employee's home and is not the spouse, child, sister, or parent of the Active Employee or Active Employee's spouse.

"Scientific Evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the Intervention on Health Outcomes. If controlled clinical trials are not available, observational studies that demonstrate a casual relationship between the Intervention and Health Outcomes can be used. Partially controlled observational studies and uncontrolled clinical studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a casual relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

"Treating Physician" means a Physician who has personally evaluated the patient.

"Trust Agreement" means the Agreement and Declaration of Trust establishing the Southern California Dairy Industry Security Fund and any modification, amendment, extension and renewal thereof.

"Trustees" shall mean any persons designated as Trustees pursuant to the terms of the Trust Agreement, and the successor of each from time to time in office.

"Union" means any of the Local Unions affiliated with the Southern California Dairy Industry Security Fund signatory to hereto and the terms "Unions" means all the Local Unions signatory hereto.

"Uniformed Services" mean service in the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty training or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

Notice of Privacy Practices

General Information About This Notice

The Southern California Dairy Industry Security Fund (the "Plan") is committed to maintaining the confidentiality of your private medical information. This Notice describes our efforts to safeguard your health information from improper or unnecessary use or disclosure. This Notice only applies to health-related information created or received by or on behalf of the Plan. We are providing this Notice to you because privacy regulations issued under federal law, the Health Insurance Portability and Accountability Act of 1996, 45 CFR Parts 160 and 164 ("HIPAA"), require us to provide you with a summary of the Plan's privacy practices and related legal duties, and your rights in connection with the use and disclosure of your Plan information.

In this Notice, the terms "Plan," "we," "us," and "our" refer to the Plan and third parties to the extent they perform administrative services for the Plan. When third party service providers perform administrative functions for the Plan, we require them to appropriately safeguard the privacy of your information.

Please note:

- ***If you are enrolled in an HMO you will also receive a separate notice from your HMO provider that describes the HMO provider's specific use and disclosure of your health information. Your rights with respect to their use and disclosure of your health information are set forth in that separate notice.***

What is Protected?

Federal law requires the Plan to have a special policy for safeguarding a category of medical information called "protected health information," or "PHI," received or created in the course of administering the Plan. PHI is health information that can be used to identify you and that relates to:

- ***your physical or mental health condition,***
- ***the provision of health care to you, or***
- ***payment for your health care.***

Your medical and dental records, your claims for medical and dental benefits, and the explanation of benefits ("EOB's") sent in connection with payment of your claims are all examples of PHI.

The remainder of this Notice generally describes our rules with respect to your PHI received or created by the Plan.

If you have any questions regarding this Notice, please contact:

Privacy Officer
Southern California Dairy Industry Security Fund
c/o Southwest Administrators, Inc.
P.O. Box 1121
Alhambra, CA 91802-1121
Phone (877) 350-4792

Uses and Disclosures of Your PHI

To protect the privacy of your PHI, the Plan not only guards the physical security of your PHI, but we also limit the way your PHI is used or disclosed to others. We may use or disclose your PHI in certain permissible ways described below. To the extent required under federal health information privacy law, we use the minimum amount of your PHI necessary to perform these tasks.

- ***To determine proper payment of your Health Plan benefit claims.*** The Plan uses and discloses your PHI to reimburse you or your doctors or health care providers for covered treatments and services. For example, your diagnosis information may be used to determine whether a specific procedure is medically necessary or to reimburse your doctor for your medical care.

- ***For the administration and operation of the Plan.*** We may use and disclose your PHI for numerous administrative and quality control functions necessary for the Plan's proper operation. For example, we may use your claims information for fraud and abuse detection activities or to conduct data analyses for cost-control or planning-related purposes.

- ***To inform you or your health care provider about treatment alternatives or other health-related benefits that may be offered under the Plan.*** For example, we may use your claims data to alert you to an available case management program if you are diagnosed with certain diseases or illnesses, such as diabetes.

- ***To a health care provider if needed for your treatment.***

- ***To a health care provider or to another health plan to determine proper payment of your claim under the other plan.*** For example, we may exchange your PHI with your spouse's health plan for coordination of benefits purposes.

- ***To another health plan for certain administration and operations purposes.*** We may share your PHI with another health plan or health care provider who has a relationship with you for quality assessment and improvement activities, to review the qualifications of health care professionals who provide care to you, or for fraud and abuse detection and prevention purposes.

- ***To a family member, friend, or other person*** involved in your health care if you are present and you do not object to the sharing of your PHI, or it can reasonably be inferred that you do not object, or in the event of an emergency.

- ***For Plan design activities or to collect Plan contributions.*** The Plan may use summary or de-identified health information for Plan design activities. In addition, Plan employees may use information about your enrollment or disenrollment in a Plan in order to collect contributions that pay for your Plan participation.

- ***To the Plan Sponsor.*** The Plan may disclose PHI to the Plan sponsor, the Board of Trustees, to the extent provided by a rule of the Plan, provided that the sponsor protects the privacy of the PHI and it is only used for the permitted purposes described in this Notice.

- ***To Business Associates.*** The Plan may disclose PHI to other people or businesses that provide services to the Plan and which need the PHI to perform those services. These people or businesses are called business associates, and the Plan will have a written agreement with each of them requiring each of them to protect the privacy of your PHI. For example, the Plan may have hired a consultant to evaluate claims or suggest changes to the Plan, for which he needs to see PHI.

- ***To comply with an applicable federal, state, or local law,*** including workers' compensation or similar programs.

- ***For public health reasons,*** including (1) to a public health authority for the prevention or control of disease, injury or disability; (2) to a proper government or health authority to report child abuse or neglect; (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration; (4) to notify individuals of recalls of medication or products they may be using; or (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.

- ***To report a suspected case of abuse, neglect or domestic violence,*** as permitted or required by applicable law.

- ***To comply with health oversight activities,*** such as audits, investigations, inspections, licensure actions, and other government monitoring and activities related to health care provision or public benefits or services.

- ***To the U.S. Department of Health and Human Services*** to demonstrate our compliance with federal health information privacy law.

- ***To respond to an order of a court or administrative tribunal.***

- ***To respond to a subpoena, warrant, summons or other legal request*** if sufficient safeguards, such as a protective order, are in place to maintain your PHI privacy.

- ***To a law enforcement official for a law enforcement purpose.***

- ***For purposes of public safety or national security.***

- ***To allow a coroner or medical examiner to make an identification or determine cause of death or to allow a funeral director to carry out his or her duties.***

- ***To respond to a request by military command authorities*** if you are or were a member of the armed forces.

- ***For cadaveric organ, eye or tissue donation.*** The Plan may use and disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

- ***For research.*** The Plan may use and disclose protected health information to assist in research activities, regardless of the source of the funding for the research, where a

privacy board or an Institutional Review Board has approved an alteration to or waived entirely the authorization requirements of the law and the Plan receives certain specific representations and documentation.

- ***To avert serious threat to health or safety.*** The Plan may use and disclose protected health information to prevent or lessen a serious threat to health or safety of any one person or the general public and the use or disclosure is (1) to a person or persons reasonably able to prevent or lessen the threat to health or safety or (2) necessary for law enforcement authorities to identify or apprehend an individual.

- ***Incident to a permitted use or disclosure.*** The Plan may use and disclose protected health information incident to any use or disclosure permitted or authorized by law.

- ***As part of a limited data set.*** The Plan may use and disclose a limited data set that meets the technical requirements of 45 Code of Federal Regulations, Section 164.514(e), if the Plan has entered into a data use agreement with the recipient of the limited data set.

- ***For fundraising.*** The Plan may use and disclose certain types of protected health information to a business or to an institutionally related foundation for the purpose of raising funds. The types of information that may be disclosed under this exception to the authorization requirement are: (1) demographic information relating to an individual and (2) dates of health care provided to an individual. The fundraising materials must inform you of how you may elect to opt out of receiving further fundraising communications that are healthcare operations. The entity that sends you such communications must treat your request to opt out as a revocation of your authorization to receive any such communications.

Absent your written permission, Plan employees will only use or disclose your PHI as described in this Notice. Plan employees will not access your PHI for reasons unrelated to Plan administration without your express written authorization.

If an applicable state law provides greater health information privacy protections than the federal law, we will comply with the stricter state law.

Other Uses and Disclosures of Your PHI

Before we use or disclose your PHI for any purpose other than those listed above, we must obtain your written authorization. You may revoke your authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI except as described above (or as permitted by any other authorizations that have not been revoked). However, please understand that we cannot retrieve any PHI disclosed to a third party in reliance on your prior authorization.

In no event will the Plan use or disclose your PHI that is "genetic information" for "underwriting purposes," as such terms are defined by the Genetic Information Nondiscrimination Act of 2008.

Your Rights

Federal law provides you with certain rights regarding your PHI. Parents of minor children and other individuals with legal authority to make health decisions for a Plan participant may exercise these rights on behalf of the participant, consistent with state law.

Right to request restrictions: You have the right to request a restriction or limitation on the Plan's use or disclosure of your PHI. For example, you may ask us to limit the scope of your PHI disclosures to a case manager who is assigned to you for monitoring a chronic condition. Because we use your PHI to the extent necessary to pay Plan benefits, to administer the Plan, and to comply with the law, it may not be possible to agree to your request. Except in the limited circumstances described below, the law does not require the Plan to agree to your request for restriction. Except as otherwise required by law (and excluding disclosures for treatment purposes), the Plan is obligated, upon your request, to refrain from sharing your PHI with another health plan for purposes of payment or carrying out health care operations if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. The Plan will not agree to any restriction, which will cause it to violate or be noncompliant with any legal requirement. If we do agree to your requested restriction or limitation, we will honor the restriction until you agree to terminate the restriction or until we notify you that we are terminating the restriction with respect to PHI created or received by the Plan in the future.

You may make a request for restriction on the use and disclosure of your PHI by completing the appropriate request form available from the Plan.

Right to receive confidential communications: You have the right to request that the Plan communicate with you about your PHI at an alternative address or by alternative means if you believe that communication through normal business practices could endanger you. For example, you may request that the Plan contact you only at work and not at home.

You may request confidential communication of your PHI by completing an appropriate form available from the Plan. We will accommodate all reasonable requests if you clearly state that you are requesting the confidential communication because you feel that disclosure in another way could endanger your safety.

Right to inspect and obtain a copy of your PHI: You have the right to inspect and obtain a copy of your PHI that is contained in records that the Plan maintains for enrollment, payment, claims determination, or case or medical management activities. If the Plan uses or maintains an electronic health record with respect to your PHI, you may request such PHI in an electronic format, and direct that such PHI be sent to another person or entity.

However, this right does not extend to: (1) psychotherapy notes, (2) information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (3) any information, including PHI, as to which the law does not permit access. We will also deny your request to inspect and obtain a copy of your PHI if a licensed health care professional hired by the Plan has determined that giving you the requested access is reasonably likely to endanger the life or physical safety of you or another individual or to cause substantial harm to you or another individual, or that the record makes references to another person (other than a

health care provider), and that the requested access would likely cause substantial harm to the other person.

In the event that your request to inspect or obtain a copy of your PHI is denied, you may have that decision reviewed. A different licensed health care professional chosen by the Plan will review the request and denial, and we will comply with the health care professional's decision.

You may make a request to inspect or obtain a copy of your PHI by completing the appropriate form available from the Plan. We may charge you a fee to cover the costs of copying, mailing or other supplies directly associated with your request. You will be notified of any costs before you incur any expenses.

Right to amend your PHI: You have the right to request an amendment of your PHI if you believe the information the Plan has about you is incorrect or incomplete. You have this right as long as your PHI is maintained by the Plan in a designated record set. We will correct any mistakes if we created the PHI or if the person or entity that originally created the PHI is no longer available to make the amendment. However, we cannot amend PHI that we believe to be accurate and complete.

You may request amendments of your PHI by completing the appropriate form available from the Plan.

Right to receive an accounting of disclosures of PHI: You have the right to request a list of certain disclosures of your PHI by the Plan. The accounting will not include disclosures (1) to carry out treatment, payment and health care operations, (2) to you, (3) incident to a use or disclosure permitted or required by law, (4) pursuant to an authorization provided by you, (5) for directories or to people involved in your care or other notification purposes as permitted by law, (6) for national security or intelligence purposes, (7) to correctional institutions or law enforcement officials, (8) that are part of a limited data set, (9) that occurred prior to April 14, 2003, or more than six years before your request. Your first request for an accounting within a 12-month period will be free. We may charge you for costs associated with providing you additional accountings. We will notify you in advance of any costs, and you may choose to withdraw or modify your request before you incur any expenses.

You may make a request for an accounting by completing the appropriate request form available from the Plan.

Right to Receive Notice: If your "Unsecured" PHI is accessed, acquired, used or disclosed in a manner that is impermissible under the HIPAA privacy rules and that poses a significant risk of financial, reputational or other harm to you, the Plan must notify you within 60 days of discovery of such "Breach" (as such terms are defined in the HIPAA privacy rules).

Right to file a complaint: If you believe your rights have been violated, you should let us know immediately. We will take steps to remedy any violations of the Plan's privacy policy or of this Notice.

You may file a formal complaint with our Privacy Officer and/or with the United States Department of Health and Human Services at the addresses below. You should attach any evidence or documents that support your belief that your privacy rights have been violated. We

take your complaints very seriously. **The Plan prohibits retaliation against any person for filing such a complaint.**

Complaints should be sent to:

Privacy Officer
Southern California Dairy Industry Security Fund
c/o Southwest Administrators
P.O. Box 1121
Alhambra, CA 91802-1121
Phone: (877) 350-4792
FAX: (626) 299-5146

Region IX, Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: (415) 437-8310
FAX: (415) 437-8329
TDD: (415) 437-8311
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Additional Information About This Notice

Changes to this Notice: We reserve the right to change the Plan's privacy practices as described in this Notice. Any change may affect the use and disclosure of your PHI already maintained by the Plan, as well as any of your PHI that the Plan may receive or create in the future. If there is a material change to the terms of this Notice, you will receive a revised Notice.

How to obtain a copy of this Notice: You can obtain a copy of the current Notice by contacting the Privacy Officer at the address listed on the front of this Notice.

No change to Plan benefits: This Notice explains your privacy rights as a current or former participant in the Plan. The Plan is bound by the terms of this Notice as they relate to the privacy of your protected health information. However, this Notice does not change any other rights or obligations you may have under the Plan. You should refer to the Plan documents for additional information regarding your Plan benefits.

Your ERISA Rights

As a Participant in certain of the various employee benefit plans described in this guide, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Administrator or at other specified locations, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund Administrator with the US Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Fund Administrator, copies of all Plan documents, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated summary plan descriptions. The Administrator may make a reasonable charge for these copies.

- Receive a summary of the Plans' annual financial report. The Plan's administrator is required by law to furnish each Participant with a copy of such summary annual reports.

Continue Group Health Plan Coverage

- Continue health care coverage for you or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan and the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your subsequent group health plan (if applicable), if you have proof of creditable coverage, available free of charge, from this group health plan or health insurance issuer and you request it before losing coverage or up to twenty-four (24) months after losing coverage: (1) when you lose coverage under this Plan; (2) when you become entitled to elect COBRA coverage; (3) or when your COBRA continuation coverage ceases.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Active Employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your Union, or other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any detail, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or Federal court, after first exhausting the Plan's claims and appeals procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court after first exhausting the Plan's claims and appeals procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court loss and legal fees. If you are successful, the court may order the person you have sued to pay these costs and legal fees. If you lose, the court may require you to pay these costs and legal fees; for example if the court finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Fund Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents form the Fund Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor Los Angeles Regional Office, 1055 East Colorado Blvd., Suite 200, Pasadena, CA 91106-2341. The phone number for the Los Angeles Regional Office is (626) 229-1000. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 275-7922.

ERISA Information

1. Plan Name and Plan Sponsor

This Plan is known as the Southern California Dairy Industry Security Fund – Active Plan.

The Plan Sponsor is:

Board of Trustees
Southern California Dairy Industry Security Fund
Post Office Box 1121
Alhambra, CA 91802-1121
(626) 284-4792

2. Plan Identification Numbers

1. The employer identification number is EIN 95-6060456.
2. The Plan number is PN 501

3. Type of Welfare Plan and Funding Organization

The Plan is a collectively bargained, joint-trusteed labor-management trust. A complete list of the employer organizations sponsoring the Plan may be obtained upon written request to the Fund Administrator and is available for examination at the Fund Administrator's office.

This welfare Plan provides Hospital and medical benefits, vision care, prescription drug benefits, and group life benefits for Active Employees and their covered Dependents and weekly disability benefits for Active Employees only.

4. Organizations Through Which Benefits are Provided:

The carriers listed below provide fully insured benefits under the Plan:

United Healthcare P.O. Box 6006 Cypress, CA 90630 (800) 624-8822	Provides insured prepaid medical benefits.
Kaiser Permanente 393 East Walnut Pasadena, CA 91188 (800) 464-4000	Provides insured prepaid medical benefits.
ULLICO 111 Massachusetts Ave., N.W. Washington, D.C. 20001 (800) 431-5425	Provides insured Life benefits.

United Concordia 21700 Oxnard Street, Suite 500 Woodland Hills, CA 91367 (800) 876-6432	Provides insured Dental benefits.
Liberty Dental 4675 MacArthur Court, Ste. 625 Newport Beach, CA 92660 (888) 703-6999	Provides insured Dental benefits.

The Plan is self-funded (claims are paid directly from the assets of the Fund) for the benefits listed below. These carriers administer at least a portion of the benefits for the Plan, but do not insure or otherwise guarantee any of the benefits of the Plan:

Vision Service Plan 111 West Ocean Boulevard Suite 1625 Long Beach, CA 90802-4519	Administers the vision benefit and provides access to its network of vision providers. For Active Employees and Dependents only.
Medco 30012 Ivy Glen Suite 270 Laguna Niguel, CA 92677	Administers the prescription drug benefit and provides access to its Network of pharmacies.
First Health 3200 Highland Avenue Downers Grove, IL 60515	Provides case management and access to its network of Hospitals and medical providers.
Health Management Center / APS 8403 Colesville Road, Ste. 1600 Silver Spring, MD 20910	Administers the mental health and substance abuse benefits and provides access to its network of providers.

5. Type of Administration

The type of administration of this Plan is Contract Administration.

6. Fund Administrator

The Fund is administered by the following third party administrator:

Southern California Dairy Industry Security Fund
Southwest Administrators, Inc.
Mailing Address:
Post Office Box 1121
Alhambra, CA 91802-1121
Street Address:
1000 South Fremont Avenue, A-9 West
Alhambra, CA 91803
www.swadmin.com

The Fund Administrator's telephone number is (626) 284-4792.

7. Agent for Service of Legal Process

The person designed as Agent for Service of legal process is:

Southern California Dairy Industry Security Fund
Southwest Administrators, Inc.
Mailing Address:
Post Office Box 1121
Alhambra, CA 91802-1121
Street Address:
1000 South Fremont Avenue, A-9 West
Alhambra, CA 91803
www.swadmin.com

Service of legal process may be made upon the Fund Administrator or any Trustee.

8. Source of Plan Contributions

Benefits are provided primarily from employer contributions determined as a result of Collective Bargaining. A self-payment is required for Retired Employee coverage and for enrollment in some higher cost plans.

9. Date Fiscal Year Ends

The fiscal year for this Plan ends, each year, on May 31.

10. Claims Procedures

The Claims and Appeals Procedures are detailed on pages 58-60.

11. Collective Bargaining Agreements

Contributing Employers are responsible form making monthly contributions into the Fund on behalf of all eligible employees and their eligible dependents. The amount of contribution is determined by the Board of Trustees under the authority of maintenance of benefit provisions contained in the collective bargaining agreement between various Teamsters Local Unions and Contributing Employers. A complete list of the Contributing Employers and participating Unions may be obtained by Participants and beneficiaries upon written request to the administrator. You may also receive from the administrator, upon written request, information as to whether a particular employer or Union is a sponsor of the Plan and, if so, its address. The Fund Administrator will provide you, upon request, with a copy of the applicable Collective Bargaining Agreement. You will be charged a reasonable amount for copying.

12. Trustees of the Plan

The names, titles, and business address of the Trustees of the Plan as of June 1, 2011 are as follows:

Union Trustees

Mike Bergen
Teamsters Union Local 166
18597 Valley Boulevard
Bloomington, CA 92316-089

Robert Rios
Teamsters Union Local 166
18597 Valley Boulevard
Bloomington, CA 92316-089

Martin Perez
Teamsters Union Local 63
845 Oak Park Road
Covina, CA 91724

Jim Hetrick
Teamsters Union Local 952
140 South Marks Way
Orange, CA 92868-2698

Employer Trustees

Jack Noenickx
Stremicks Heritage Foods, LLC
4002 Westminster Avenue
Santa Ana, CA 92703-1310

Lowell T. Richardson
Dean Foods Pacific Coast Group
17637 E Valley Blvd
City of Industry, California 91744

Important Notice of
Your Right to Documentation of Health Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a pre-existing condition exclusion generally may not be imposed for more than twelve (12) months (eighteen (18) months for al ate enrollee). The twelve (12)-month (or eighteen (18)-month exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a pre-existing conditions exclusion. Contact your State Insurance department for further information.

You have the right to receive a certificate of prior health coverage. Check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

To obtain a certificate, complete this form and return it to:

Southern California Dairy Industry Security Fund
Southwest Administrators, Inc.
Post Office Box 1121
Alhambra, CA 91802-1121

For additional information contact the Fund Administrator at: (877) 350-4792 or (626) 284-4792.

The certificate must be provided to you promptly. Keep a copy of this completed form. You may also request certificates for any of your Dependents (including your spouse) who were enrolled under your health coverage.

Request for Certificate of Health Coverage

Name of Participant:_____Date:_____

Social Security Number:_____

Address:_____

Telephone Number:_____

Name and relationship of any Dependents for whom certificates are requested (and if their address is different from above):

_____

_____

Eligibility Rules for Benefit Programs for Retirees

Teamsters members employed with companies participating in the Southern California Dairy Industry Security Fund have contributions paid on their behalf under their Collective Bargaining Agreement to the Western Conference of Teamsters Pension Fund and to the Southern California Dairy Industry Security Fund for future retiree benefits. The Pension Fund provides pension benefits to qualified participants and the Dairy Fund provides medial and prescription benefits to qualified retirees. Your eligibility for a Teamsters' pension benefit does not include health and welfare benefits. You may qualify for a pension, but not qualify for the Dairy Retiree Program. YOU MUST APPLY TO EACH FUND SEPARATELY FOR PENSION AND RETIREE HEALTH BENEFITS.

You are eligible as a Retired Employee if you retired on or after January 1, 1964 and meet the following requirements:

- You have attained age 60 (age 55 if you retired on or after April 1, 1967), and have completed at least 15 years of continuous employment with one or more contributing employers immediately prior to your retirement date; or

- You qualify under the Golden 84 Rule. PEER coverage (Program for Enhanced Early Retirement) will permit eligible employees to retire early with full benefits under the Western Conference of Teamsters Pension Fund. The Golden 84 Rule applies to participants whose age plus years of service equal or exceed 84. The retiree qualifying under the Golden 84 Rule must still satisfy the Fund's requirement of completing at least 15 years of continuous employment with one or more contributing employers immediately prior to the retirement date; or

- You became Totally Disabled, and have completed at least 15 years of continuous employment with one or more contributing employers immediately prior to the date such disability commenced and are receiving Federal Social Security benefits for Total Disability; and

- You reside in the United States or any of its possessions; and

- You do not engage in gainful employment within the same industry within the same geographical area as is covered by this Plan, for a contributing employer; and

- On and after January 1, 1987, you make the required self-payment.

Twelve (12) full calendar months of unemployment, or non-covered employment, will be considered a break with respect to the continuous employment requirement.

All employees of a Single Independent Distributor (Class IV), retiring on or after May 1, 1995 are not eligible for retiree benefits. However, if you were an employee of a Single Independent Distributor, retired prior to May 1, 1995 and were receiving benefits, you and your spouse shall continue to be eligible for benefits.

If you are considering retirement, please contact Southwest Administrators, Inc., to request a Dairy Retiree Application and a Dairy Fund Retiree booklet to review the Dairy Trust Retiree Qualification Rules for health and welfare benefits.

Consultant:

Rael & Letson
35 North Lake Avenue, Suite 810
Pasadena, CA 91101

Administered by:

Southwest Administrators, Inc.

Mailing Address:
Post Office Box 1121
Alhambra, CA 91802-1121
626-284-4792 or 877-350-4792

Street Address:
1000 South Fremont Avenue, A-9 West
Alhambra, CA 91803

www.swadmin.com