SECURITY FUND

RETIRED EMPLOYEES PLAN

Southern California Dairy Industry Security Fund

September 1, 1998 Edition

SOUTHERN CALIFORNIA DAIRY INDUSTRY SECURITY FUND

To all retired employees covered by the Plan:

We are pleased to present you with this new booklet which describes the benefits provided by your Plan including changes that have been made to the Plan through September 1, 1998.

If you elect to be enrolled in one of the prepaid plans, those benefits are described in separate booklets. This booklet describes all other benefits including: (1) the rules that determine your rights to any benefits; (2) how to file a claim; and (3) the ERISA disclosure information covering the funding of benefits and your right to appeal benefit denials.

Please pay special attention to the Pre-Admission Certification required for all non-emergency inpatient hospitalizations if you are enrolled in the Fee-For-Service Plan. If you fail to obtain Pre-Admission Certification, your benefit payments will be reduced by 50%. For more information, refer to pages 23 and 24.

This booklet tells you:

- how you become covered;
- what your benefits are; and
- how to file a claim for benefits.

This is only a summary of your benefits. The final authority is the actual Plan document which governs the benefits. We encourage you to share this booklet with your spouse since he/she also has an interest in the benefits available under the Plan. Because there have been several changes made since the printing of the last benefit booklet, we urge you to familiarize yourself with the new benefits available and your rights to those benefits.

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

Sincerely,

BOARD OF TRUSTEES

ATENCION A LOS MIEMBROS QUE HABLAN ESPANOL:

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 comuniquese con la oficina del Administrador al telefono:

1-626-284-4792 or 1-877-350-4792

AUTHORIZED SOURCE OF INFORMATION

The only sources of authorized information are the benefit booklets and booklet inserts, if any, the Trust Agreement, the Rules and Regulations, the contracts from the various provider organizations, and the written statements of the Fund Administrator and his/her authorized agents and legal representatives. Statements or representations made by individuals other than those designated personnel are not authoritative sources of information. Questions as to eligibility, benefits, and other matters should be submitted to your Fund Office.

AMENDMENT AND TERMINATION

In order that the Fund may carry out its obligation to maintain within the limits of its resources, a program dedicated to providing the maximum possible benefits for all participants, the Board of Trustees expressly reserves the right, in its sole discretion at any time and from time to time:

- to terminate or amend the conditions of eligibility for any benefit even though such termination or amendment affects claims which have already accrued;
- to terminate the Plan even though such termination affects claims which have already accrued;
- to alter or postpone the method of payment of any benefit; and
- to amend or rescind any other provisions of the Plan.

DISCLAIMER

A certain portion of the benefits described in this booklet are paid directly from the assets of the Fund, and there is no liability on the Board of Trustees, any individual, or entity to provide payments over and above the amounts in the Fund collected and available for such purposes. Any benefits provided by the Plan can be paid only to the extent that the Fund has available adequate resources for payment. No employer has any liability to make payments for any benefits that may be due, and is only obligated to make any contributions in accordance with the terms of the Collective Bargaining Agreement. There is also no obligation on the Board of Trustees, either individually or collectively, nor upon any Employer, Union, Association, or upon any person or entity to provide benefit payments, if the Fund does not have sufficient assets to provide benefit payments.

TABLE OF CONTENTS

Page

TABLE OF CONTENTS

SUMMARY OF BENEFITS

For Retirees enrolled in the Fee-For-Service Medical Expense Plan

- You and your eligible spouse are covered under all benefits described in this Summary of Benefits.

For Retirees enrolled in a Prepaid Medical Plan

- You and your eligible spouse are covered by Kaiser or PacifiCare for hospital and medical benefits. Refer to the separate Kaiser or PacifiCare benefit booklet for a description of those benefits. Retirees enrolled in a prepaid plan **must** use its prescription drug program. Mental Health and Substance Abuse coverage is provided through the Teamsters Referral Program provided by Health Management Center. See page 26 for details.

BENEFITS	COVERAGE AMOUNT
Indemnity Prescription Drug Program Benefits	
Reimbursement Plan	75% of covered expenses
Provided by Medco	
Walk-In Program	30-day supply; $2 generic co-payment; $5 brand name co-payment
Mail Order Program	90-day supply; mandatory for maintenance drugs for the third refill and after[1]; $2 co-payment per prescription
Fee-For-Service Comprehensive Medical Expense Benefits -	
Lifetime Maximum Benefit	$500,000 per person
Calendar Year Deductible	$100 per person
Out-of-Pocket Maximum	$1,000 of Allowable Charges per person per calendar year (in addition to the Calendar Year deductible)
Coinsurance	
Inpatient Hospital	
PPO[2]	100% of negotiated rates
Non-PPO	70% of Allowable Charges
Outpatient Hospital	
PPO[2]	80% of negotiated rates
Non-PPO	70% of Allowable Charges

[1]Benefits not payable if program not used.

[2]A PPO hospital means a hospital which has a contract with the Fund to provide services at specified fees.

BENEFITS	COVERAGE AMOUNT
Pre-Admission Testing[1]	80% of negotiated rates
Emergency Room[1]	80% of negotiated rates
Hospital Charges for Outpatient Surgery	
PPO[2]	80% of negotiated rates
Non-PPO	70% of Allowable Charges
Physician -	
PPO	80% of negotiated rates
Non-PPO	70% of Allowable Charges
Chiropractic Benefits	80%; up to a maximum payment of $20 per visit and 20 visits per calendar year
All Other Benefits	80% of Allowable Charges

[1]70% 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.

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

(2) You must use a PPO provider (except in an emergency situation or where no PPO providers are accessible) for your professional and hospital services, **otherwise benefits will be reduced to 70% of Allowable Charges, unless you reside more than 20 miles from the nearest PPO provider.**

(3) The Teamsters Referral Program provided by Health Management Center must be utilized before receiving non-emergency treatment for Mental and Nervous Disorders or Substance Abuse, **otherwise no benefits will be paid.**

ELIGIBILITY

Retiree Eligibility

You are eligible for benefits 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.

Six 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.

Dependent Eligibility

The lawful spouse of a Retired Employee is an eligible dependent. **Dependent children are not covered.**

What is the Required Self-Payment?

In order to be eligible as a Retired Employee you are required to make a monthly self-payment. The amount of the self-payment is determined by the Board of Trustees and may be amended from time to time. The self-payment must be made in the following manner:

- all self-payments must be made in the form of a certified check or money order.
- your self-payment must be for a minimum of three months and must be received by the Fund Office no later than the first day of the first month of the three month period for which coverage is desired. For example, if you wish to have coverage for the months of January, February and March, your self-payment must be received by the Fund Office by January 1.
- if the Fund Office does not receive your self-payment by the date it is due, you will be notified in writing that your eligibility for benefits has been terminated, and you will not again be eligible for benefits under this Plan.

Effective Date of Eligibility

Retired Employees

If you make the required self-payment, your eligibility for benefits will start on the later of the following dates:

- July 1, 1988, if you were eligible for benefits as a Retired Employee on June 30, 1988; or
- the first day of the month following termination of your active employment with a contributing employer.

Spouses

If the required self-payment is made, your spouse will be eligible on the date you become eligible or on the date you acquire the spouse, whichever is later.

Termination of Eligibility

Retirees -

Your eligibility as a Retired Employee will terminate on the earliest of the following dates:

- the date on which this Plan is terminated by the Trustees;

- the date on which you no longer reside in the United States or any of its possessions;
- the first day of the month following the month in which you engage in gainful employment within the same industry, within the same geographical area as covered by this Plan, for a contributing employer;
- the first day of the month for which the required self-payment has not been received by the Fund Office;
- the first day of the month following the month in which the contributing employer you were last employed by prior to retirment ceases to be a participating employer in the Plan; or
- the date of your death.

Spouses -

Your spouse's eligibility will terminate on the earliest of the following dates:

- the date of death of the covered retiree;
- the date you and your spouse are divorced, or legally separated;
- the date of your loss of eligibility;
- the date of entrance into full-time, active military service;
- the date the Plan, or benefits for dependents, is terminated by the Board of Trustees; or
- the first day of the month for which the required self-payment has not been received by the Fund Office.

If loss of eligibility occurs, your spouse may be able to continue coverage under the provisions of COBRA. See page 8 "Rights of a Dependent Spouse".

COBRA CONTINUATION COVERAGE

Continuation of Benefits

The Continuation of Benefits Retirement Act is a federal law known as "COBRA". This Act requires that group health plans offer covered employees and their families the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances (called "qualifying events"), where coverage under the Plan would otherwise end. To receive this continuation coverage, the retiree or spouse must pay the monthly premiums directly to the Fund. This section of the booklet is intended to inform you of your rights and obligations regarding COBRA continuation coverage. You should take the time to read this carefully.

Rights of a Dependent Spouse

If you are the spouse of a covered retiree and you lose Fund health coverage for one of the following reasons (qualifying events) you will have the right to elect continuation coverage for a maximum of 36 months after any one of the following qualifying events occurs:

(1) the death of your spouse; or

(2) divorce or legal separation from your spouse.

Period of COBRA Continuation Coverage

If you elect COBRA continuation coverage you may continue your coverage under the Retired Employees' Plan for a maximum of three years.

Duty to Notify Fund Office

Under the law, the covered retiree or family member must inform the Fund Office within 60 days of a death, divorce, or legal separation.

You are encouraged to inform the Fund Office promptly of any qualifying event to assure prompt handling of your rights for continuation coverage. The Fund Office is located at:

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

Deadline for Election of Continuation Coverage

When the Fund Office is notified that a qualifying event has occurred, the necessary forms for enrollment will be sent to you along with other information regarding COBRA continuation coverage. The completed forms must be returned to the Fund Office within 60 days from the date coverage would otherwise terminate, or, if later, the date the Fund Office mailed the notice advising you of your election rights to make your decision. You do not need to show proof of insurability to obtain COBRA continuation coverage.

If you elect continuation coverage, you will be entitled to the same health coverage that is provided to similarly situated Retirees or spouses in the plan you were enrolled in when the qualifying event took place. Continuation coverage can only be elected for the Plan you were enrolled in when the qualifying event took place. You may change your plan selection only during the Fund's annual open enrollment period.

Payment Obligations

The initial self-payment must be submitted to the Fund Office within 45 days from the spouse's election date. The initial payment must cover the number of months from the date of coverage that would otherwise have terminated, including the month in which the initial payment is made. **Payment must be made by either a money order or a cashier's check and sent or delivered to the Fund Office** at the address shown above.

If the required monthly payments are paid when due, coverage will continue. **The Fund Office will not send monthly bills or warning notices.** It is the responsibility of the qualified spouse to submit payments when due.

Termination of COBRA Continuation Coverage

Continuation coverage will terminate as of the date the maximum period has been reached as described previously. However, continuation coverage will terminate earlier for any of the following reasons:

1. the plan is terminated by the Board of Trustees (in which case you may have the opportunity for coverage under other group health plans sponsored by the Fund); or

2. your premium for COBRA continuation coverage is not paid by the last day of the coverage month; or

3. coverage is obtained under another employer or trust funded group health plan, as an employee or spouse of an employee, unless the group health plan contains a provision that would limit coverage for a pre-existing condition of a qualified beneficiary in which case COBRA continuation coverage will not cease until the date the condition is covered under the new plan or the

maximum time allowed under COBRA coverage is reached, whichever occurs first; or

4. the individual becomes entitled to Medicare.

If you have any questions, please contact the Fund Office. Also remember to notify the Fund Office immediately of any changes in marital status, dependent status (addition or deletion) or address changes.

Health Insurance Portability and Accountability Act (HIPAA)

Effective June 1, 1997, when your coverage terminates, you will receive a "Certificate of Coverage". The Certificate provides information regarding the period of coverage under this Plan. This information may be used to reduce or eliminate a pre-existing condition limitation period under a new group health plan, under which you become covered. You may also request a copy of the Certificate at any time within 24 months after your coverage terminates. If your spouse loses eligibility separately and the Fund Office is notified that the spouse is no longer an eligible spouse, a separate Certificate will be provided for that spouse; This Certificate may also be requested within 24 months after the Spouses's coverage has been terminated.

CHOICE OF MEDICAL PLANS FOR YOU AND YOUR SPOUSE

Three medical benefit plan options are available to you and your eligible spouse:

- **A Fee-For-Service Plan provided directly through the Fund.** If you are enrolled in this option, you and your eligible spouse will be covered under the Fund's Fee-For-Service Medical Expense Plan for hospital and medical services and supplies. You may use any doctor or hospital in the United States.

- **A Prepaid Health Plan provided through PacifiCare.** You must live within 30 miles of a PacifiCare Medical Group or Independent Physician Association (IPA) in order to enroll in this plan. If you enroll in this plan, you and your eligible spouse will be covered under the PacifiCare Plan for the hospital and medical services and supplies. All retirees and their spouses enrolled in PacifiCare must use the PacifiCare prescription drug plan.

- **A Prepaid Health Plan provided through Kaiser Foundation Health Plan.** You must live within 30 miles of any Kaiser medical facility in order to enroll in this plan. If you enroll in this plan, you and your eligible spouse will be covered under the Kaiser Plan for all hospital and medical services and supplies. All retirees and their spouses enrolled in Kaiser must use the Kaiser prescription drug plan.

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 during any Open Enrollment period. The necessary forms are available from the Fund Office. A newly eligible Retiree and his/her spouse will be automatically enrolled in the Fee-for-Service Plan provided by the Fund, unless he/she specifically signs up for the PacifiCare Plan or the Kaiser Plan. A description of the Fee-for-Service Medical Expense Plan provided by the Fund is included in this booklet. Descriptions of the Prepaid Plans are in the separate Kaiser and PacifiCare booklets.

COORDINATION OF BENEFITS

You or your spouse may be covered by other group health plans which can result in dual coverage. The Southern California Dairy Industry Security Fund was created to help you meet the cost of health care and was not intended to provide greater benefits than our actual expenses. The Health Plan, therefore, will be coordinated with all other group plans so that the total of the benefits you receive will not exceed 100% of the covered expenses you incur.

This Coordination of Benefits provision does not apply to any personal policies you may own. Refer to the section entitled "Benefits for Individuals Eligible for Medicare" on how Fund benefits are determined if you are eligible for Medicare. Please note that the rules apply whether or not you actually enroll in Medicare.

MEDICARE

How to Enroll in Medicare

If you are approaching age 65, you are not automatically enrolled in Medicare unless you have filed an application and established eligibility for a monthly Social Security benefit. If you have not applied for Social Security benefits, you must file a Medicare application form during the three month period prior to the month in which you become 65 years of age in order for coverage to begin at the start of the month in which you reach age 65. Call or write your nearest Social Security Office 90 days prior to your 65th birthday and ask for an application card.

Benefits For Individuals Eligible for Medicare

On the first day of the month in which an individual becomes eligible for Medicare, the benefits that would be payable under Medicare will be coordinated with the Fund's regular benefits, whether or not the individual has enrolled for Medicare. That is, the Fund pays the lesser of the Plan's scheduled benefit or the amount that Medicare does not pay. **For example, assume the retiree was charged $50 for an eye exam and Medicare provides a $40 benefit for eye exams and the Dairy Plan provides a $30 benefit. The Dairy Plan would pay $10.** The claimant will receive the reduced amount calculated by the Fund as described.

THIRD PARTY ASSIGNMENTS

If you or your spouse have an illness, injury, disease or other condition for which a third party may be liable or legally responsible by reason of negligence or other legal cause on the part of such third party, you or your spouse, as a condition precedent to entitlement to benefits from this Plan, are required to execute an assignment to this Plan. The assignment is for any proceeds received by way of judgment, settlement or otherwise in connection with, or arising out of any claim for damages by you or your spouse. The assignment will be in an amount equal to, but not in excess of, the payments to be made by the Plan on account of medical, hospital, surgical and other expenses in connection with, or arising out of the injury, illness, disease or other condition for which the third party may be responsible.

FEE-FOR-SERVICE COMPREHENSIVE MEDICAL EXPENSE BENEFITS - FOR ELIGIBLE RETIREES AND THEIR SPOUSES ENROLLED IN THE FEE-FOR-SERVICE COMPREHENSIVE MEDICAL EXPENSE PLAN

Your Comprehensive Medical Expense Plan contains a Hospital Pre-Admission and Continued Stay Review Program, a mandatory PPO physician and hospital network, and a Teamsters Referral Program. Each of these programs is described fully on pages 23 through 27.

Benefits may be reduced 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 expense 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 25.

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 33.

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 Expenses** not payable by the Plan), total $1,000 during the calendar year. When this $1,000 "Co-Payment Limit" is reached, the Plan pays 100% of Allowed Expenses incurred thereafter during the same calendar year by that same individual, subject to the "Lifetime Maximum Benefit." However the Co-Payment Limit provision **does not apply to certain expenses.** Please see the section below entitled "Co-Payment 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 your spouse.

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 you and your spouse 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.

The Co-Payment Limit

The Co-Payment 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 a calendar year is $1,000 of Allowable Charges subject to the Lifetime 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.

Lifetime Maximum Benefit

The Lifetime Maximum Benefit is $500,000 per person. This means that no more than $500,000 will be paid under the Comprehensive Medical Expense on account of each covered person. However, if benefits have been paid during a year, the amount paid up to $1,000 will be automatically reinstated each January 1.

Also, if you or your spouse have received Comprehensive Medical Expense Benefits in excess of $1,000, you may be entitled to a full restoration of the maximum benefit by submitting, at your own expense, evidence of good health to the Fund.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Effective January 1, 1999, 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 consultation 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 the mastectomy; including lymphademas

This coverage is subject to the plan's annual deductibles, coinsurance and other relevant provisions of this 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 Plan Administrator at (626) 284-4792 or (877) 350-4792.

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 70% of allowable charges 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 23 through 24.

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 70% of the Allowable Charges 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 a sudden onset of illness or for accidental injuries) to a non-PPO hospital, you will be entitled to full plan benefits.

This Plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain authorization from the **Plan** (or its utilization review company) for prescribing a length of stay not in excess of those periods. Discharge may occur earlier than these time periods if both the mother and the physician agree. However, expenses for the newborn child are not considered Covered Expenses.

Outpatient Services -

- If you or your spouse 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 80% of the hospital's negotiated charges for necessary services and supplies other than physician services. Use of a non-PPO hospital is payable at 70% of allowable charges.

- If you or your spouse 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 48 hours of the injuries, the Plan will pay 80% of the hospital's negotiated charges for such expenses. Use of a non-PPO hospital is payable at 70% of Allowable Charges.

Home Health Care

The Plan will pay 80% of the Allowable Charges you or your spouse incur for the following services received 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 spouse 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 spouse, 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 spouse'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 spouse during a period for which a physician has indicated a prognosis of less than six months to live:

- 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 $1,500 for outpatient Hospice Care except with prior approval);
- medical social services; and
- bereavement counseling, not to exceed $200.

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

Chiropractic Benefits

The Plan will pay 80% of the Allowable Charges incurred by you or your spouse for treatment provided by a chiropractor, up to a maximum payment of $20 per visit and 20 visits per calendar year. In addition, benefits for x-rays ordered by a chiropractor will be limited to a maximum payment of $65 per calendar year.

Mental and Nervous Disorders 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 Teamsters Referral Program. However, there is a lifetime maximum of 50 days of inpatient care for the treatment of mental and nervous disorders. There is no limit on the number of days of outpatient treatment for mental health and substance abuse. Charges related to the treatment of alcoholism or drug addiction are limited to $10,000 per lifetime.

In certain circumstances, these benefits may be reduced. Please refer to page 26 for further information concerning the Teamsters Referral Program.

Wellness Benefit

Effective October 1, 1998 the Plan will pay 80% of the Allowable Charges incurred for routine physical examinations received from a PPO contracting provider as follows:

- Employee and Spouse under age 40
  up to $500 once every two calendar years (pap smears are a covered expense each calendar year)

- Employee and Spouse age 40 and over
  up to $500 every calendar year

Other Services and Supplies

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

- services of a PPO physician[1];
- services of an anesthetist;
- services of a Registered Nurse;
- x-ray, radium, and radioactive isotope therapy;
- physical therapy treatments provided by a registered physical therapist;
- required x-ray and laboratory examinations;
- 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.

[1]Benefits will be reduced to 70% of allowable charges if a non-PPO physician is utilized where a PPO provider is accessible.

LIMITATIONS AND EXCLUSIONS

In addition to the General Limitations and Exclusions listed on page 32, and any limitations or exclusions contained in the benefit descriptions, Comprehensive Medical Expense Benefits are not payable for expenses in connection with:

- reconstruction of prior surgical 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 which occurs while you or your spouse are covered under this Plan;
- 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;
- 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 months following the date of the injury;
- services or supplies for the removal of corns or calluses, or trimming of toenails, treatment of chronic conditions of the foot such as weak or fallen arches, flat or pronated metalorsalgia, or foot strain;
- inpatient admissions primarily for diagnostic studies when inpatient bed care is 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;

- more than three weeks of inpatient hospital care in connection with the confinement of a terminally ill patient unless prior approval has been obtained from the Fund Office, and in no circumstances will such benefits exceed a maximum of six consecutive months;

HOW TO FILE A CLAIM

Claims are to be submitted to the Fund Office at the following address:

Southern California Dairy Industry Security Fund
Southwest Administrators, Inc.
Post Office Box 1121
Alhambra, CA 91802-1121
Telephone: (626) 284-4792 or (877) 350-4792

All claims must be filed within ninety (90) days of the date the charges are incurred. However, if circumstances cause a delay, claims will be accepted only within 12 months of the date services or supplies were received.

Claim forms are available from the Fund Office, the Local Union Office or your employer. Be sure that all sections of the form are properly completed and that all bills, suitably itemized, are attached before submitting your claim for payment.

Remember - prompt payment of your claim will depend upon your submission of complete information.

HOW TO APPEAL A CLAIM DENIAL

When a claim is submitted to the Administrative Office, the claim is processed according to the Plan's rules. If you receive an answer to a claim with which you disagree, you may submit a request in writing to the Administrative Office asking for a review of the decision. The written request for review must be received by the Administrative Office within six months from the date of your receipt of the answer with which you disagree. You may submit any additional evidence or argument to support your position. A review will then be made and you will be advised in writing of the decision of that Review Committee.

This decision will include a written explanation giving detailed reasons for the denial, specific reference to the Plan provisions on which the denial is based, and a description of any additional material or information necessary for you to perfect the claim.

This written explanation shall be furnished to you within 60 days after receipt by the Administrative Office of your request for review unless special circumstances require an extension of time for processing your review. If such an extension is required, you will be given written notice of that extension and in no event shall the extension exceed an additional 60 day period.

After the written explanation of the review is received, if you believe you are adversely affected by such decision, you or a duly authorized representative of your choice may file a request for an appeal.

The request for an appeal must be in writing and submitted through the Administrative Office. The appeal must be submitted within 60 days from the date of receipt of the review decision. The appeal may be rejected if it is not submitted within this 60 day period.

The request for an appeal must contain an outline of the matter involved along with any issues, comments or explanations of the applicant's position. Additional written documentation may also be presented. The applicant may also request that he and/or his authorized representative be present for the appeal.

The appeal will be heard within 60 days of the receipt of the request for the appeal unless special circumstances require an extension of that time. In that event, notice will be given to the applicant of the extension, which, in no event, shall be longer than an additional 60 days.

The decision of the Appeals Committee shall be given in writing to you and shall include specific reasons and references to pertinent Plan provisions or documents on which the decision is based. The decision of the Appeals Committee shall be final and binding upon the applicant.

This appeals procedure shall be the sole and exclusive procedure available to an individual who is dissatisfied with a claim or eligibility decision of any kind relating to the self-insured benefits of the Fund.

HOSPITAL PRE-ADMISSION AND CONTINUED STAY REVIEW PROGRAM - FOR RETIREES AND SPOUSES ENROLLED IN THE FEE-FOR-SERVICE MEDICAL EXPENSE BENEFITS PLAN

Provided by Case Management Horizons, Ltd. (CMH, Ltd.)

> **NOTE: For treatment of a nervous or mental condition or substance abuse, refer to page 26 for a description of Teamsters Referral Program. The CMH, Ltd. program does not apply to these types of cases.**

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 resolved.

How does the Program Work?

When your doctor recommends that you be hospital confined, tell him that he must contact Case Management Horizons, Ltd. (CMH, Ltd.) at (800) 462-4275 at least 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 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), CMH, Ltd. 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 your spouse are admitted to a hospital on an emergency basis, the hospital should follow the procedure for continued stay review by contacting CMH, Ltd. within 72 hours of the admission, and then they will review your records to determine the necessity of your admission and the appropriate length of stay.

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN - FOR RETIREES AND SPOUSES ENROLLED IN THE FEE-FOR-SERVICE MEDICAL EXPENSE BENEFITS PLAN

As noted in the various descriptions contained in this booklet, if you or your spouse obtain services from a PPO doctor or hospital, your out-of-pocket expenses will be less.

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.

  If you do not have the PPO listing of participating hospitals and doctors, you can obtain one from the Fund Office. You may also call First Health at 800-544-2830 for a participating hospital or doctor in your area.

- 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 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.

- 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.

Why Use PPO Hospitals and Doctors?

- The Plan will pay a higher percentage of Covered Expenses for hospital charges.

- PPO Doctors have agreed to provide medical services to eligible 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. 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 UTILIZATION REVIEW, CASE MANAGEMENT, AND QUALITY ASSURANCE REVIEW PROGRAM (TEAMSTERS REFERRAL PROGRAM)

Provided By Health Management Center, Inc. (HMC)

What is the Teamsters Referral Program?

The Teamsters Referral Program is a mental health and substance abuse utilization review, case management, and quality assurance program that was instituted in recognition of the fact that the dollars spent on the treatment of mental health and substance abuse related illnesses are consuming an increasing part of the Plan's total health care dollars.

The purpose of the program is to coordinate care for mental health related problems and 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 of mental and nervous or alcohol and substance abuse diagnoses. 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 any medical plan, you and your eligible spouse will receive both mental health and substance abuse coverage under this program.

How does the Program Work?

If you or your spouse need hospitalization or outpatient treatment for a mental and nervous disorder or substance abuse, **you must contact the Teamsters Referral Program prior to receiving treatment in order to receive maximum benefits.** If you or your spouse receive treatment **without the prior approval and referral of the Teamsters Referral Program,** there will be **no payment of benefits.** The Teamsters Referral 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. In the event of an emergency hospitalization, maximum benefits will be paid only if you contact the Teamsters Referral Program within 48 hours of the admission.

For assistance and information call:

1-800-327-4103

Refer to the Schedule of Benefits on page 27 for a summary of the services provided and your co-payments.

SCHEDULE OF BENEFITS FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

MENTAL HEALTH -	
Inpatient Care -	
Annual Benefit Maximum	25 days
Lifetime Benefit Maximum	50 days
Days to be determined based on the following ratios:	
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	25 visits
Lifetime Benefit Maximum	Unlimited
Co-payment Individual Session[1] 1-25	$0 co-pay
Coinsurance Level	100% of contracted network provider's charges
CHEMICAL DEPENDENCY -	
Inpatient/Outpatient Care -	
Lifetime Benefit Maximum	$10,000 including detoxification
Coinsurance Level	100% of contracted network facility's charges
Substance Abuse Professional (SAP) Services	100% of contracted network facility's charges

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

PRESCRIPTION DRUG PROGRAM - FOR ALL RETIREES AND THEIR SPOUSES ENROLLED IN THE FEE-FOR-SERVICE PLAN

The Fund has entered into an agreement with Merck-Medco Containment Services, Inc., the parent company of PAID Prescriptions, Inc. and National Pharmacies, Inc. to provide prescription drugs to its members at discounted prices. The walk-in program is known as PAID Prescriptions and the mail order program is known as National Rx. Please contact the Administrative Office for a listing of the PAID Prescription participating pharmacies.

When you and your spouse are eligible for the Fee-For-Service 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.

1. **PAID Exclusive Provider Network Participating Pharmacies**: You may go to any PAID Exclusive Provider Network (EPN) participating pharmacy and obtain your prescription by paying a $2 co-payment for each generic prescription and a $5 co-payment for each brand name prescription. A claim form is not necessary. Present your 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 SPOUSE OF A RETIREE MUST KNOW THE RETIREE'S SOCIAL SECURITY NUMBER TO RECEIVE THIS BENEFIT. The PAID 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 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 PAID pharmacy for a refund after authorization has been obtained from the Fund.

   Using the PAID Drug Plan, a 30-day supply plus two refills is allowable, providing your doctor prescribed that amount. If you need several months of your prescription while you are on vacation, you will be required to pay the co-payment for each 30-day supply.

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

For those retired participants who live fifteen (15) miles or more from an EPN pharmacy, you may submit a claim to the Fund Office and be reimbursed up to 75% of the covered expenses for your prescription(s). A 30-day supply is allowable per prescription. However, you must still utilize the mail order prescription drug program for the third refill and those thereafter for all maintenance medication. A 90-day supply is allowable for all mail order prescription.

2. **National Rx Mail Order**: 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 National Rx, along with the prescription form provided by your doctor. The co-payment for mail order drugs is $2 per prescription for up to a 90-day supply. The mail order service will send the prescribed drugs directly to you. You will usually receive your prescription within two days. You may contact the Administrative Office for this mail order form.

   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 $5 co-payment at your walk-in pharmacy. If **you** request that your prescription be filled with a brand name drug rather than a generic drug, your co-payment will be the difference in cost between the brand and generic medication.

Most prescribed drugs are available under their 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 name 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/her to add the phrase "or generic equivalent" to your prescription. This will help your pharmacist provide you with a more reasonably priced product.

What Drugs are Covered?

- Drugs which, under Federal or State of California Law, requires the written or oral prescription of a physician.
- In addition, only the following items, which do not require a prescription by law, are covered if they are prescribed by a Physician for a specific illness:
  - insulin and diabetic supplies, including: insulin syringes, needles, disposable needles, sugar test tablets, sugar test tape, acetone test tablets, 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 medications; or
  - miscellaneous: Gamma Globulin, Epinephrine, USP, Ephedrine Sulfate--25 mg. (3/8 gr.), and Ferrous Sulfate, USP.
- Prescriptions dispensed by a physician in his/her own office which are otherwise covered under this program and for which a separate charge is made by the Physician.

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 effective October 1, 1998,
- vitamins, cosmetics, dietary supplements, health and beauty aids, mother's milk or artificial blood;
- injectable drugs;
- any drugs not reasonably necessary for the care or treatment of bodily injuries or sicknesses;
- charges for prescription drugs containing in excess of a 30-day supply (90-day supply for maintenance drugs);
- smoking deterrents;
- nose drops or other nasal preparations;
- immunization agents, biologicals, blood or blood plasma;
- drugs necessary for sickness or accident covered by any Workers' Compensation or Occupational Disease Law;
- non-drug items;
- fertility medications;
- drugs whose sole purpose is to promote or stimulate hair growth; and
- experimental or investigational drugs; and
- Effective October 1, 1998, up to six (6) viagra pills per month when purchased through the walk-in pharmacy.

GENERAL LIMITATIONS AND EXCLUSIONS

(not applicable to the PacifiCare Plan or Kaiser Plan)

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 for 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 injuries 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 recovered or can be recovered, either by adjudication, settlement or otherwise, under any 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 atomic explosion;
- 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 purposes 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.
- treatment that is **not** considered Medically Necessary.

DEFINITIONS

"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 justified based on the complexity or severity of treatment for a specific case, as determined by the Board of Trustees and revised from time to time. With respect to charges made for services contained in the California Relative Value Study (i.e. physician care, x-ray and laboratory) "Allowable Charge" means the product of the unit value in the CRVS multiplied by the conversion factor 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.

"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 the Allowable Charges definition.

"Dependent" means the Retired Employee's lawful spouse;

"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.

"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.

"He", **"him"**, **"his"** and **"himself"** shall apply to both genders whenever used without "she", "her", or "herself".

"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 Federal Medicare.

"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 participation as a "hospice facility" under Medicare.

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 hospice team that visits patients; and

(c) units operated as part of a Health Maintenance Organization.

(2) free-standing Hospital-affiliated Hospice;

(3) in-home care program:

(a) hospital based;

(b) nursing-home based; or

(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.

"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 that the services, supplies, treatment, and confinement must be generally recognized in the physician's profession as effective and essential for treatment of the injury or illness for which it is ordered; and that they must be rendered at the appropriate level of care in the most appropriate setting based on diagnosis. To be considered "Medically Necessary," the care must be based on generally recognized and accepted standards of medical practice in the United States and it must be the type of care that could not have been omitted without an adverse effect on the patient's condition or the quality of medical care. In addition, services, treatment, supplies, or

confinement shall not be considered "Medically Necessary" if they are an Experimental Procedure, or if investigational or primarily limited to research in their application to the injury or illness; or if primarily for scholastic, educational, vocational, or developmental training; or if primarily for the comfort, convenience or administrative ease of the provider or the patient or his/her family or caretaker.

"Medicare" means the program established under Title XVIII of the Social Security Amendments Act (Federal Health Insurance for the Aged) as it is presently constituted or may hereafter be amended.

"Plan" means the Southern California Dairy Industry Security Fund established by the Trust Agreement. The term "Fund" also 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 applicable 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 Retired Employee or the Retired Employee's spouse.

"Registered Nurse" as used under the Fee-For-Service benefit descriptions means a registered nurse who does not ordinarily reside in the Employee's home and is not the spouse, child, brother, sister, or parent of the Retiree or Retiree's spouse.

"Retired Employee" means any former Active Employee who meets the eligibility requirements as set forth in the Rules and Regulations Providing Health and Welfare Benefits for Retired Employees.

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

"Trustees" shall mean any persons designated as Trustees pursuant to the terms of the Trust Agreement, and the successor of such person from time to time in office. The terms "Board of Trustees" and "Board" mean the Board of Trustees established by the Trust Agreement.

"Union" means any of the Local Unions affiliated with the Teamsters Miscellaneous Security Trust Fund signatory hereto and the term "Unions" mean all of the Local Unions signatory hereto.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

1. **Name of Plan.** This Plan is known as the Southern California Diary Industry Security Fund - Retiree Plan.

2. **Plan Administrator and Sponsor.** The Board of Trustees is the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974.

   The Fund Office will provide you upon written request, information as to whether a particular employer or union is a sponsor of the Plan and the address of the employer or union.

3. **Name and Address of the Board of Trustees.** The Board of Trustees consists of an equal number of employer and union representatives, selected by the employers and unions, in accordance with the Trust Agreement which relates to this Plan.

   If you wish to contact the Board of Trustees, you may use the address and phone number below:

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

   The routine functions of the Plan are performed by:

   Southwest Administrators, Inc.
   Post Office Box 1121
   Alhambra, CA 91802-1121
   (626) 284-4792

4. **Names, Titles, and Addresses of any Trustee or Trustees.** As of September, 1998, the Trustees of this Plan are:

Union Trustees

James King
Teamsters Union Local No. 952
140 South Marks Way
Orange, CA 92668-2698

Employer Trustees

Tom Dolan
Driftwood Dairy
10724 Lower Azusa Road
El Monte, CA 91731

Union Trustees (continued)

Kurt S. Larsen
Teamsters Union Local No. 630
750 South Stanford Avenue
Los Angeles, CA 90021

Thomas O'Rourke
Teamsters Union Local 630
750 South Stanford Avenue
Los Angeles, CA 90021

Employer Trustees (continued)

Suzanne Blake
Santee Dairies, Incorporated
17851 East Railroad
City of Industry, CA 91748

Jack Noenickx
Adohr Farms, LLC
4002 West Westminster Avenue
Santa Ana, CA 92703-1373

Rosalie Ross
Ross Swiss Dairies
1739 Albion Street
Los Angeles, CA 90031

5. **IRS Identification Numbers.** The number assigned to the Plan by the Internal Revenue Service is EIN 95-6060456. The Plan number is 501.

6. **Agent for Service of Legal Process.** The designated agent for the 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

   The service of legal process may also be made upon a Plan Trustee.

7. **Collective Bargaining Agreement and Source of Contributions.** Participating Employers are responsible for 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 employers and the International Brotherhood of Teamsters located within the jurisdiction of Joint Council of Teamsters No. 42 and No. 92. 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 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.

8. **Type of Plan.** This is a Welfare Plan which provides hospital and medical benefits, and prescription drug benefits for retired employees and their covered dependents.

9. **Trust Fund.** The Trust's assets and reserves are held in trust by the Board of Trustees (item 4 above) of the Southern California Dairy Industry Security Trust Fund.

10. **Identity of Providers of Benefits.** This Plan is partially self-funded. Some Benefits are provided through a Health Maintenance Organization (HMO) – Kaiser Permanente and PacifiCare. Premiums are paid to the HMOs for this coverage on behalf of participants who have elected coverage under the HMO. Any claims dispute involving the HMOs must be handled directly with the HMOs. Claims dispute for all other benefits (which are self-insured by the Fund) must be handled directly through the Fund Office. You may contact the insurance providers at:

Fully Insured Benefits

Kaiser Permanente
393 East Walnut
Pasadena, CA 91188

PacifiCare
5701 Katella Avenue
Cypress, CA 90630

Self-Insured Benefits

Merck-Medco Containment Services, Inc.
Paid Prescriptions, Inc./ National Pharmacies, Inc.
30012 Ivy Glenn,
Suite 270
Laguna Niguel, CA 92677

Case Management Horizons, Ltd. (CMH)
4343 North Clarendon #1616
Chicago, IL 60613

Merck-Medco Containment Services, Inc.
Paid Prescriptions, Inc./ National Pharmacies, Inc.
30012 Ivy Glenn
Suite 270
Laguna Niguel, CA 92677

Health Management Center, Inc. (HMC)
270 Farmington Avenue
Suite 210
Farmington, CT 06032

11. **Fiscal Plan Year.** The fiscal records of the Plan are kept separately for each Fiscal Plan Year. The Fiscal Plan Year begins on June 1 and ends on May 31.

12. **The Plan's Requirements With Respect to Eligibility for Participation and Benefits.** The eligibility requirements are specified on pages 5 and 6 in the front of this booklet.

13. **Circumstances Resulting in Disqualification, Ineligibility or Denial or Loss of Benefits.** Loss of eligibility is described on pages 6 and 7 in the front of this booklet.

14. **Procedures to Follow for Filing a Claim.** The procedure to be followed in filing a claim for benefits is outlined on page 21. All claims for benefits must be submitted on claim forms made available by the Fund Office. Claims submitted must be accompanied by information or proof requested and reasonably required to process such claims.

15. **Review Procedure.** The following provisions do not apply to services and supplies provided through Kaiser or PacifiCare. Kaiser and PacifiCare have their own review and appeals procedures which are described in its Disclosure Form/Evidence of Coverage booklet.

    If your claim is denied in whole or in part, you will receive a written explanation giving detailed reasons for the denial, specific reference to the Plan provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and an explanation of why such information or material is necessary, as well as an explanation of the claims appeal procedure.

    The above written explanation shall be furnished to you within 90 days after receipt of your claim by the Fund, unless special circumstances require an extension of time for processing your claim. If such extension is required, you will be furnished written notice of that extension prior to the termination of the 90-day period and in no event shall this extension exceed a period of 90 days from the end of the initial 90-day period. The extension notice shall indicate the special circumstances requiring the extension and the date by which the Fund expects to give its final decision on your claim. In the event you do not receive notice from the Fund within the above time limits, your claim shall be considered denied. You may petition the Board of Trustees for review of the denial and must do so as a condition precedent to judicial review. The appeals procedure is described on page 21.

16. **Availability of Documents and Other Important Information.** As a participant in the Southern California Dairy Industry Security Fund - Retiree Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

    Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents, including

insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 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 a state or federal court. 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 state or federal court.

The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U. S. Department of Labor, Los Angeles Regional Office, 790 E. Colorado Blvd, Suite 514, Pasadena, California.

Nothing in the foregoing is meant to interpret or extend or change in any way the provisions expressed in the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgement, conditions so warrant.