SUMMARY
COMPARISON OF
MEDICAL & DENTAL
PLANS
FOR RETIREEs EXCEPT CLASS E

UNITED FOOD & COMMERCIAL WORKERS UNIONS
AND FOOD EMPLOYERS BENEFIT FUND
Table Of Contents

Introduction ............................................. 3

Medical Benefits ........................................ 3

Monthly Premiums ........................................ 4

Enrollment .................................................. 5

Your Health Care Choices
Depend On Where You Live ............................. 6

Active Participants
Planning Retirement ..................................... 6

Annual Open Enrollment
For Retirees ............................................... 6

Retirees Living In California ............................ 8

Comparing Medical Plans ................................ 8
  Indemnity PPO Medical Plan ....................... 8
  HMO Plans ............................................... 11
  Acupuncture and Chiropractic Benefits .......... 12
  Podiatry Benefits ...................................... 13
  Employee Member Assistance
  Program (EMAP) ....................................... 14

Dental Plan Coverage .................................. 15
  General Information .................................. 15
  Indemnity Dental Plan ............................... 16
  Prepaid Dental Plans ................................ 17

Coordination Of Benefits .............................. 18

Medicare .................................................... 19
  Medicare Part B ....................................... 20

When You Can Change Plans ......................... 20
Introduction
This booklet is a brief summary of the health care coverage available to Retirees. Whether you are already retired, or still employed and planning retirement, this booklet can help you make decisions about your health care coverage and will inform you of the facts you need to know when accessing health care services.

Please read it carefully so that you will understand the benefits provided, the choices of plans available to you, and the requirements of the Retiree Health Care Plan.

Medical Benefits
The United Food & Commercial Workers Unions and Food Employers Benefit Fund provides benefits for Retirees to help cover the cost of doctors’ services, hospital stays, specialist care and other health care services. For those who are not yet eligible for Medicare, the Plan pays benefits in accordance with plan limits and allowances. For those who are eligible for Medicare, refer to page 19.

To provide the maximum benefits available under the Indemnity PPO Medical Plan, the Fund contracts with Preferred Provider networks in California to provide the services of doctors, hospitals and other medical service providers who have agreed to charge Fund Retirees lower, “preferred customer” rates. So, you’ll save money when you receive your care from Preferred Providers in the network.
Monthly Premiums
Retirees are required to pay monthly premiums as a condition of participation in the Retiree Health Care Plan. The monthly premiums are as follows:

a. Retiree Not Eligible for Medicare
   Retiree Only - $90
   Family - $180
b. Retiree Eligible for Medicare
   Retiree Only - $40
   Family - $80
c. Retiree and Dependent(s), Only One Person Eligible for Medicare
   Family - $130

The monthly premium will be deducted from your pension check if you have authorized it. If your pension check is insufficient to cover the premium payment or if you do not want the deduction and have not authorized it but have elected coverage, you will receive your entire pension check and will be required to send the premium payment to the Fund Office.

Premiums must be paid before eligibility can be granted. Premiums must be paid no later than the last day of a month for coverage for the next month.

For example: the premium for April coverage must be paid no later than March 31st. If the premium is not paid by that date, coverage will terminate. Coverage can be reinstated if a late payment is received within the next 30 days, or April 30th in this example.

However, after this 30-day period, your coverage will be terminated and cannot be reinstated until the third regular Open Enrollment period that follows the date your coverage ended.

Enrollment
You do not need to complete an Enrollment Form to keep your current plan coverage for yourself and your eligible dependents, if any.

If you have eligible dependents, you may cover yourself only (single coverage) or your entire family (family coverage). If you have elected and paid for the premium for family coverage, your eligible dependents can be covered under your plan, providing they meet the Fund requirements for eligibility.

If you are married and elect single coverage, your dependents will not be covered under the UFCW Retiree Health Care Plan. However, if you are enrolled in the UFCW Retiree Dental Plan, your dependents will be covered for dental benefits.

You must complete an Enrollment Form if you wish to change to a different medical plan. You must also complete an Enrollment Form and the Authorization Form if you wish to change from single enrollment to family enrollment or from family to single. Include all required documentation of dependent eligibility, such as photocopies of marriage and birth certificates if you are adding new dependents.
You may decline medical and dental coverage entirely by checking the appropriate box on the Authorization Form or Enrollment Form. If you decline to enroll for medical coverage for you and/or your spouse or domestic partner, you may not re-enroll until the third Open Enrollment following this declination. Should you or your spouse or domestic partner lose other employer or union group medical coverage, you may enroll in this Plan without waiting for the third Open Enrollment.

Your Health Care Choices Depend On Where You Live

For many Retirees who live in California, the Benefit Fund provides the opportunity to choose between the Indemnity PPO Medical Plan with the Prudent Buyer Option and HMO coverage through one of the HMOs offered by the Fund.

Active Participants Planning Retirement

If you are about to retire, this booklet and other materials you receive will help you to choose the medical plan and dental plan that suit you best and will give you important information about the need to enroll in Medicare or a Medicare HMO when you become eligible.

Annual Open Enrollment For Retirees

The United Food & Commercial Workers Unions and Food Employers Benefit Fund Open Enrollment usually takes place in November and December for a January 1st effective date.

The Fund’s Annual Open Enrollment gives you the opportunity to:

- Change from your current medical plan to a different one (if you live in an area where Fund HMOs are offered),
- Enroll in the Dental Program if you are eligible to do so, or
- Disenroll from the Dental Program if you have been enrolled during the past year.

Even if you don’t anticipate making a change in your coverage, Open Enrollment is the time to:

- Review your medical coverage,
- Review and update, if necessary, the family members you may have enrolled in the Plan.

To make changes in your health care coverage, complete an Enrollment Form and send it to the Fund Office. You can also use an Enrollment Form to update dependent information.

If you live in an area where the Fund does not provide Medical PPO network or HMO options, you should take the time at Open Enrollment to:

- Review the status of your dental coverage
- Update dependent information.
Retirees Living In California
If you live in Southern California in an area served by the HMOs offered by the Fund, available medical plans are:

- Indemnity PPO Medical Plan with the Prudent Buyer Option - www.anthem.com/ca
- Aetna Medical Plan - HMO* www.aetna.com
- Kaiser Foundation Health Plan Inc. (Kaiser Permanente), an HMO, or Kaiser Permanente Senior Advantage*, Kaiser’s Medicare HMO - www.kaiserpermanente.org
- PacifiCare, A United Healthcare Company, an HMO, or SecureHorizons*, PacifiCare’s Medicare HMO - www.pacificare.com

If your area in California is not served by one of the listed HMOs, you are automatically covered under the Indemnity PPO Medical Plan with the Prudent Buyer Option.

*To be enrolled in Aetna Medicare Plan - HMO, Kaiser Senior Advantage, or PacifiCare SecureHorizons, you must be enrolled in Medicare Part A and Part B.

Comparing Medical Plans
For a comparison between the major features of the Plans, please refer to the comparison charts that follow page 23.

Indemnity PPO Medical Plan
The Indemnity PPO Medical Plan features the Prudent Buyer Network within California which offers significant discounts on covered health care services and supplies. It provides up to $1,500,000 in benefits for each covered person’s lifetime.

The Indemnity PPO Medical Plan provides:
- Coverage for hospitalization
- Coverage for medically necessary diagnostic X-ray and lab
- Coverage for doctors’ charges and other medical expenses

For those who utilize the Prudent Buyer PPO Network, the Plan can help you save money on your medical bills and make your medical plan benefits go further.

There is a Calendar-Year Deductible under the PPO Plan. A deductible is a specific amount of expense that you will pay before the Plan begins to pay its benefits. You may satisfy the deductible with a combination of expenses. The deductible does not apply toward your Annual Coinsurance Out-of-Pocket Maximum.

Your Annual Coinsurance Out-of-Pocket Maximum (OOP) is a limit on your expenditures in a calendar year. The OOP is lower for services received in the PPO network than for services received outside the network. If your share of the Covered Charges exceeds the maximum OOP, the Plan will pay 100% of your Covered Charges for the remainder of that calendar year except for copays and expenses that exceed Plan allowances or benefit limitations.

Individual benefit limits (such as the limit for chiropractic care and acupuncture) will apply whether or not the OOP has been reached.
A copay (or copayment) is a fixed dollar amount of money that is your share of the charges for medical services you receive. Copays do not apply toward the deductible or to your Annual Coinsurance Out-of-Pocket Maximum.

**Coinsurance** is your percentage share of the charges for medical services you receive. It is not a set amount and will vary by the cost of the procedures although the percentage remains the same. Coinsurance does not apply to the deductible.

**Covered Charges** are the charges or expenses incurred by a Participant while eligible under the Plan, which are:

- Expressly covered under the applicable provisions of the Plan,
- Medically necessary, and
- the lesser of the following:
  
  a. the negotiated rate of a PPO Provider,
  b. the Usual, Customary and Reasonable (UCR) charge,
  c. the charge billed by the physician or other provider, or
  d. the amount determined under the applicable plan provision.

If you receive services from a non-PPO provider, the charges may be higher and your out-of-pocket expenses will be higher.

**Hospital pre-certification** is automatically processed if services are received through the PPO network.

Pre-certification is NOT automatic outside the PPO network, so be sure you let your doctor know that you need to do this before receiving hospital services. There is a 20% reduction in benefits for non-compliance if the Participant is out-of-area or at a non-PPO facility.

If you are enrolled in Medicare, you do not need hospital pre-certification since Medicare is your primary coverage.

If you receive **emergency room treatment**, you must pay the copay but you do not have to pay the deductible before receiving benefits from the Plan. The copay will be waived if you are admitted to the hospital within 24 hours.

**HMO Plans**

The HMOs generally cover many medical services with a $25 copay. However, you must live in the Service Area of the HMO you choose and you are restricted to using only that Plan’s doctors and hospitals. If you use a doctor or hospital not affiliated with your HMO, your charges will not be reimbursed. Within an HMO, you may be required to choose a primary care physician who will refer you to specialists as needed for your care.

Your primary care physician must be located within 30 miles of your home or work site. Individual members of your family can choose a different primary care physician or medical group. Medical care is provided including routine preventive care and wellness programs. Emergency treatment
outside your medical group’s Service Area
must be authorized by your primary care medical group or HMO.

**Acupuncture And Chiropractic Benefits**
Acupuncture and Chiropractic care benefits are provided under the Indemnity PPO Medical Plan for both Indemnity PPO Medical Plan and HMO Plan Participants.

Preauthorization of treatment is not required and Participants may obtain care from any licensed acupuncturist or licensed chiropractor they choose. However, Participants in the Indemnity PPO Medical Plan will reduce their out-of-pocket expenses by choosing providers who participate in the Anthem/Blue Cross Prudent Buyer PPO.

Acupuncture and Chiropractic treatment have the same copay as any other doctor’s visit which is $25 for both Indemnity PPO Medical Plan and HMO Participants. The Plan will reimburse 100% of the allowable amount for covered procedures minus the copay.

For Indemnity PPO Medical Plan Participants, related diagnostic testing is reimbursed at 75% of the allowable amount for covered procedures once the Participant’s annual deductible has been satisfied.

For HMO Plan Participants, related diagnostic testing is reimbursed at 75% of the allowable amount for covered procedures.

There is a $500 per calendar year combined maximum for these services, which includes related diagnostic testing.

**Podiatry Benefits**
Podiatry care is provided under the Indemnity PPO Medical Plan. The Fund contracts with Podiatry Plan Organization of California (PPOC) to provide all podiatry services to Indemnity PPO Medical Plan Participants.

**HMO Plan Participants must obtain podiatric care through their HMO network.**

PPOC is a statewide network of podiatrists who provide podiatric care. PPOC monitors the services rendered by its podiatrists to ensure that patients receive appropriate treatment and quality care.

Services provided by podiatrists who are not part of the PPOC Network are not covered under the Indemnity PPO Medical Plan. No benefits are payable for charges rendered by any podiatrist who is not a PPOC Provider.

If you need podiatric care, call your Union Local or the Fund Office for the name of a PPOC podiatrist near you.

When making an appointment, identify yourself (or your covered dependent) as a Participant in the Indemnity PPO Medical Plan of the United Food & Commercial Workers Unions and Food Employers Benefit Fund. The PPOC podiatrist will be able to verify your eligibility for the PPOC Podiatry Program. Your PPOC provider will bill the Fund directly.
Authorized PPOC treatment will be subject to the same copayments, deductibles, and coinsurance as other PPO services. You will pay a $25 copay for office visits, and other services will be reimbursed at 75% after your deductible is met.

**Employee Member Assistance Program (EMAP)**

The purpose of the Employee Member Assistance Program is to help Participants and their families deal with circumstances in their lives that can adversely affect mental health and well-being. You must use the EMAP for the services of professionals such as psychiatrists, psychologists, and marriage and family therapists, or for admission to a hospital or rehabilitation facility for treatment of mental health problems, mental illness, or alcohol or drug dependency.

The EMAP is provided through HMC/APS, an organization of health care professionals that manages the treatment of mental health problems and alcohol or drug dependency for the Fund.

For details of the EMAP Program, refer to the second page of the chart in this booklet.

**All care for mental health problems, mental illness, and alcohol or drug dependency must be obtained through the EMAP, unless you are enrolled in the Kaiser Senior Advantage, PacifiCare SecureHorizons, or Aetna Medicare Plan HMO.**

If you are enrolled in the Kaiser Senior Advantage, PacifiCare SecureHorizons, or Aetna Medicare Plan HMO, coverage is provided through your HMO network.

**Dental Plan Coverage**

**General Information**

The United Food & Commercial Workers Unions and Food Employers Benefit Fund offers both the Indemnity Dental Plan and the Prepaid Dental Plan.

Both plans cover dental services defined by the terms of the Plan as Covered Procedures. Covered Procedures are those considered necessary to prevent and eliminate oral disease and those services required to maintain and restore function. No benefits are provided for services which do not meet the definition of Covered Procedures.

**Who Is Eligible**

If you are a Retiree and have been enrolled for the year ending on December 31, 2010, your coverage will automatically continue for the period January 1, 2011, to December 31, 2011, at the current cost of coverage unless you notify the Fund Office in writing or on your Open Enrollment form that you wish to disenroll as of December 31, 2010. You may not disenroll at any other time during the year.

As a Retiree, once you disenroll from the Dental Plan, you must wait until the third Open Enrollment after rejecting dental coverage to enroll again.
If you did not enroll for dental coverage when you retired, you must wait until the second Open Enrollment after you retired to enroll.

If you are enrolled in a Medicare HMO, your enrollment and disenrollment options may be different from the rules described above. Please contact the Fund Office for details.

**Cost Of Coverage**
If you are a Retiree who elects dental coverage, you pay for this coverage and must enroll for a full year’s coverage.

For Retirees, dental coverage costs $87 per month for the period January 1, 2011, to December 31, 2011.

**Annual Benefit Maximum**
There is an $1,800 per calendar year maximum benefit per person.

**Indemnity Dental Plan**
If you choose coverage under the Indemnity Dental Plan, you may use any dentist you wish. The Plan will reimburse a portion of your dentist’s charges according to the Dental Plan Allowances after you meet your annual deductible. You pay any difference between what the Plan pays and what your dentist charges.

Dental services (except for emergency care) rendered outside of the United States are not covered under the Plan, except for those Retirees living permanently abroad. Services performed in Mexico may be covered, provided x-rays are supplied with each claim.

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**Prepaid Dental Plans**
The Prepaid Dental Plans are provided by the dental centers listed below. The Plans provide many diagnostic, preventive and restorative services at little or no charge to you. However, if you sign up for a Prepaid Dental Plan, you must obtain all of your dental services from that plan in order to have your dental charges paid for by the Plan. If you go to a dentist who is not affiliated with the Prepaid Dental Plan you have enrolled in, the charges you incur will not be paid — including charges for emergency services outside of your Prepaid Dental Plan’s Service Area.

**Prepaid Dental Plan Centers**
Dr. Schnierow and Associates  
13450 South Hawthorne Boulevard  
Hawthorne, CA 90250  
310-679-0106

Alan M. Grant, D.D.S.  
3620 Long Beach Boulevard, Suite B-6  
Long Beach, CA 90807  
562-426-6458

Affinity Dental Center  
(formerly Gary R. Winslow, DDS, Inc.)  
1920 East 17th Street, Suite 100  
Santa Ana, CA 92705  
714-953-6881

San Diego Dental Group  
5120 Baltimore Drive, Suite A  
La Mesa, CA 91941  
619-464-4242

Santa Monica Dental Center  
1244 7th Street, Suite 101  
Santa Monica, CA 90401  
310-393-0743
For a detailed comparison of the Indemnity Dental Plan to that of the Prepaid Dental Plan, please refer to the chart later in this booklet.

**Coordination Of Benefits**
The Fund uses “non-duplication of benefits.” The combined amount of benefits payable by this Fund and the other plan(s) will not exceed the benefit that would have been paid had this Fund been the primary payer. Benefits paid by this Fund will not exceed the amount that would have been paid if no other plan were involved.

If you have coverage under two or more plans, one is the primary plan while the others are secondary plans. The primary plan pays benefits first without regard to the other plans involved. The determination of which plan is primary has not changed.

If this Plan is secondary and another plan is primary, then benefits will be determined as follows:

- If the primary plan’s payment is less than the benefits provided under this Plan, then this Plan will pay the difference between its normal benefit and the amount paid by the primary plan.
- If the primary plan’s payment is the same or greater than the benefits provided under this Plan, then this Plan will not pay any additional benefits. You will still have some out-of-pocket expense even though two plans are involved. Your annual out-of-pocket maximum expense will be the amount required under your best plan.

- Any medical plan that has no coordination of benefits rule is automatically primary.

**Coordination Of Benefits With Medicare**
For Retirees eligible for Medicare, Medicare is the primary carrier. The Fund uses “non-duplication of benefits.” With non-duplication of benefits, the combined amount of benefits payable by this Fund and other plan(s), including Medicare, will not exceed the benefit that would have been paid if this Fund had been the primary payer. In other words, if the Fund would have reimbursed 75% for a given procedure, but Medicare has already paid 80%, the Fund will make no additional payments.

This may result in reimbursement of a portion of your Medicare deductibles and coinsurance.

HMO Plans cover many medical services at no charge or with a small copayment. The Fund will not reimburse you if you receive services outside your HMO or for your HMO copayments or deductibles.

**Medicare**
The Fund requires all Retirees and their dependents who reach age 65 and therefore become eligible for Medicare to enroll in both Part A and Part B of Medicare. This requirement applies no matter whether you are enrolled in an HMO or the Indemnity PPO Medical Plan. This also applies if you are eligible for Medicare as a result of receiving a Social Security Disability Award.
If you are eligible for Medicare and choose HMO coverage, the Fund requires that you enroll in that HMO’s Medicare plan.

**Medicare Part B**
If you are not enrolled in Medicare Part B, you will automatically be assigned Indemnity PPO Medical Plan coverage. Benefits paid under the Plan will be calculated as though Medicare Part B were in effect, leaving you with substantial out-of-pocket costs.

**When You Can Change Plans**
Until you become eligible for Medicare, you can change Plans once a year during Open Enrollment, generally held in November and December for an effective date of January 1st.

Outside of Open Enrollment, until you become eligible for Medicare, you can change Plans only once in a five-year period. After you become eligible for Medicare, your options are different.

**How To Enroll**
To enroll in the medical plan of your choice and to register your eligible dependents, complete an Enrollment Form. Include all required documentation of dependent eligibility, such as photocopies of marriage certificates and birth certificates if you are adding new dependents. Send the Form and documentation to the Fund Office.

Your eligible dependents will be covered under the Plan you choose as long as they meet the requirements for eligibility.

**Medicare HMO Enrollment And Disenrollment**
If you enroll in a Medicare HMO, you must complete the HMO enrollment form and the Fund’s Enrollment Form. If you wish to change from one Medicare HMO to another, simply fill out the Fund Enrollment Form and the HMO’s form and send them to the Fund Office.

Call the Fund office to get an HMO enrollment form.

If you wish to disenroll from a Medicare HMO in order to enroll in the Indemnity PPO Medical Plan, you must complete the HMO’s Disenrollment Form as well as the Fund Enrollment Form. Send both to the Fund Office.

**If You Have Questions About Your Medical Plan Choices**
Choosing a medical plan can be confusing. If you have any questions, feel free to call your Union Local or the Fund Office at the numbers listed on page 33 of this booklet.

**Filing An Indemnity PPO Medical Plan Claim And Assignment Of Benefits**

**How To File A Claim**
*All claims submitted more than 12 months after the charges are incurred will be denied.*

When you use the Prudent Buyer Network, there is no need to file claim forms. Your network provider handles the paperwork.
To file a claim for out-of-network benefits under the Indemnity PPO Medical Plan, follow these steps:

- Get a claim form from your Union Local or the Fund Office.
- Complete your portion of the form.
- Have the person providing the services complete the rest of the form, or attach the itemized bill or statement from the doctor and/or hospital securely to the claim form.
- Be sure to include your name and Social Security number on each document you submit with your claim.
- Mail the completed form to your Union Local or to:
  United Food & Commercial Workers Unions and Food Employers Benefit Fund
  P.O. Box 6010
  Cypress, California 90630-0010
- Mail additional bills or statements for any services covered by the Plan to the Fund Office as soon as you receive them.

**Assignment Of Benefits**

Benefits for charges by Network Hospitals or other Prudent Buyer network providers are paid directly to the provider of the service.

For other claims, you may request that benefits be paid directly to the provider of the service. To do so, sign the assignment portion of the claim form. Benefits will then be paid directly to the provider of the service. Any benefits due in excess of those assigned will be paid to you. The Plan may not honor an assignment to an out-of-network provider that has submitted excessive charges, charged for unnecessary services, or refused to provide its taxpayer identification.

**Notice Of Privacy Practices**

You have the right to request a copy of the Notice of Privacy Practices from the United Food & Commercial Workers Unions and Food Employers Benefit Fund. Please contact: Privacy Officer, P.O. Box 6010, Cypress, CA 90630-0010.

**COBRA Continuation Coverage**

The Plan offers COBRA Core-Plus Benefits to a Retiree’s spouse or child who has a Qualifying Event. **Qualifying Events for COBRA for the Retiree’s Spouse include** loss of coverage as a result of (a) the Retiree’s death; or (b) divorce or legal separation from the Retiree.

**Qualifying Events for COBRA for the Retiree’s Dependent Children include** loss of coverage as a result of (a) the Retiree’s death; (b) the Retiree’s divorce; or (c) the Dependent child ceasing to meet the definition of a “Dependent” as defined by the Plan.

**Women’s Health And Cancer Cancer Rights**

In accordance with federal law, all of the Fund’s medical plan options cover mastectomy-related services, including reconstruction and surgery to achieve symmetry, prostheses, and treatment for complications resulting from the mastectomy, including lymphedema. Regular plan provisions, like deductibles and coinsurance, apply.
## Summary Comparison Of Health Care Plans For Retirees Except E

### CONTRIBUTION REQUIREMENTS

Monthly contributions of $40 for a Medicare retiree or $90 for a non-Medicare retiree are required. Additional contributions are required for dependents ($40 for Medicare or $90 for non-Medicare dependents).

### DEATH BENEFITS

$1,000 to $5,000 depending on the date of retirement.

<table>
<thead>
<tr>
<th>INDEMNITY MEDICAL</th>
<th>PPO</th>
<th>Out-of-Area</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>$1,500,000 per person less amount of accumulated under the Active Medical Plan 2000+, but no less than $1,000,000. Limited to $525,000 per person for registered nurse services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$500 per person, $1,500 per family.</td>
<td>$500 per person, $1,500 per family.</td>
<td>$750 per person, $2,250 per family.</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$5,000 per person, $10,000 per family.</td>
<td>$5,000 per person, $10,000 per family.</td>
<td>$10,000 per person, $20,000 per family.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>INDEMNITY MEDICAL</th>
<th>PPO</th>
<th>Out-of-Area</th>
<th>Non-PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered charges</td>
<td>PPO contracted rates.</td>
<td>UCR charges.</td>
<td>UCR charges.</td>
</tr>
<tr>
<td>Plan Coinsurance</td>
<td>After deductible, 75%.</td>
<td>After deductible, 75%.</td>
<td>After deductible, 50%.</td>
</tr>
<tr>
<td>Additional Accident Benefit</td>
<td>$300 within 90 days of the accident.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medical Benefits

<table>
<thead>
<tr>
<th>Hospital Services</th>
<th>Inpatient. Skilled Nursing Facility (benefit for room and board at non-PPO and out-of-area facilities are limited to 50% of the semi-private room rate at the hospital from which patient was discharged). Outpatient Surgery. Alternative Birthing Center.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Payment</td>
<td>After deductible, 75%.</td>
</tr>
<tr>
<td>Hospital Precertification</td>
<td>Automatically processed by provider.</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>100% after $75 copay for treatment within 24 hours after emergency occurs. No deductible. Copay waived if admitted.</td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>100% after $75 copay. No deductible.</td>
</tr>
<tr>
<td>Ambulance</td>
<td>After deductible, 75%.</td>
</tr>
<tr>
<td>Plan Payment</td>
<td>After deductible, 75%.</td>
</tr>
<tr>
<td>INDEMNITY MEDICAL</td>
<td>PPO</td>
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<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Doctor’s Visits/Services</td>
<td>Hospital Visits. Office/Home Physician Visits, including podiatry ($3,150 maximum per calendar year, including $1,050 for Specialist Visits). Well Baby Care. Annual Physical Exam ($80 maximum per calendar year). Pap Smear Exam (two per year). PSA Screening.</td>
</tr>
<tr>
<td>Plan Payment</td>
<td>100% after $25 copay. No deductible.</td>
</tr>
<tr>
<td>Outpatient Diagnostic Services</td>
<td>Outpatient X-ray/Lab ($400 maximum per calendar year, including mammogram). Pre-Admission Testing (within 7 days of hospitalization). Pap Smear. PSA Screening.</td>
</tr>
<tr>
<td>Plan Payment</td>
<td>After deductible, 75%.</td>
</tr>
<tr>
<td>Chemotherapy/Radiation/Antigen/Infusion Drugs</td>
<td>Plan pays $10 per agent. No deductible.</td>
</tr>
<tr>
<td>Mobile Screening Units</td>
<td>Paid as any other covered services.</td>
</tr>
<tr>
<td>Family Planning</td>
<td>All FDA-approved birth control drugs and devices, excluding oral contraceptives. The effective period when one type is in use.</td>
</tr>
<tr>
<td>Plan Payment</td>
<td>After deductible, 75%.</td>
</tr>
<tr>
<td>Medical Supplies and Equipment</td>
<td>Injectable (except insulin). Artificial Limbs. Orthopedic Appliances. Glucose Home Monitor. Mastectomy Prosthesis ($315 maximum per calendar year). Orthopedic Shoes ($315 maximum per calendar year). Colostomy Supplies. Orthotics ($210 maximum per calendar year). Hearing Aids ($840 maximum for one or $1,050 for two during any three-year period). Health Aids.</td>
</tr>
<tr>
<td>Plan Payment</td>
<td>After deductible, 75%.</td>
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</tbody>
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<th>Out-of-Area</th>
<th>Non-PPO</th>
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<tbody>
<tr>
<td>Chiropractic and Acupuncture</td>
<td>$500 combined maximum per calendar year, including related x-ray/lab. Visits: $25 copayment, balance of allowed amount payable at 100%. X-ray/lab: after deductible, 75% of allowed amount.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Podiatry</td>
<td>Must be authorized by Podiatry Plan of California (PPOC) and performed by PPOC Provider. Visits: 100% of PPOC allowance after $25 copayment. Other professional services: after deductible, 75% of PPOC allowance.</td>
<td></td>
<td>Not Covered.</td>
</tr>
</tbody>
</table>

**EMAP Benefits – services must be authorized by HMC/APS and rendered by HMC/APS contract providers.**

| Inpatient Mental Health                   | After deductible, 75% of HMC/APS contracted rates. Maximum 60 days of inpatient care per calendar year, up to 120 days per lifetime. |                                               | Not Covered.                                  |
| Outpatient Mental Health                  | 100% of HMC/APS contracted rates after $25 copay. No deductible. Group therapy sessions require $12.50 copay. Maximum 30 visits per calendar year combined with outpatient chemical dependency. |                                               | Not Covered.                                  |
| Inpatient Chemical Dependency             | After deductible, 75% of HMC/APS contracted rates. $25,000 lifetime maximum per person combined with outpatient chemical dependency. |                                               | Not Covered.                                  |
| Outpatient Chemical Dependency            | 100% of HMC/APS contracted rates after $25 copay. No deductible. Group therapy sessions require $12.50 copay. Maximum 30 visits per calendar year combined with outpatient mental health. $25,000 lifetime maximum per person combined with inpatient chemical dependency. |                                               | Not Covered.                                  |
## HMO MEDICAL

<table>
<thead>
<tr>
<th>Service</th>
<th>Aetna Early Retirees</th>
<th>Aetna Medicare Plan</th>
<th>Kaiser</th>
<th>Kaiser Senior Advantage</th>
<th>SecureHorizons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td>$25 copay per visit.</td>
<td>$25 copay per visit.</td>
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</tr>
<tr>
<td>Emergency Room Visits</td>
<td>$100 copay per visit.</td>
<td>$50 copay per visit. (Waived if admitted)</td>
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</tr>
<tr>
<td>Inpatient Hospital</td>
<td>$250 copay per admission.</td>
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</tr>
<tr>
<td>Ancillary Benefits</td>
<td>Family Planning, podiatry, physical exams, immunizations, PSA screening and speech therapy are all provided through each HMO.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids, Durable</td>
<td>Provided by the HMOs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Equipment and Medical Supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable (except Insulin)</td>
<td>Provided by the HMOs. If not covered by the HMOs, paid by the Fund at 75%. After $2,500 out-of-pocket maximum per person, per calendar year, paid at 100%.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic and Acupuncture</td>
<td>Paid by the Fund at 100% of covered charges after $25 copay for office visits or 75% of UCR charges for x-ray/lab. $500 maximum per calendar year combined for all services, including x-ray/lab.</td>
<td></td>
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<tbody>
<tr>
<td>Chiropractic and Acupuncture</td>
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<td>Provided by the HMO.</td>
<td>Provided by the HMO.</td>
</tr>
<tr>
<td>Mental Health and Chemical Dependency</td>
<td>Provided through EMAP, administered by HMC/APS. Outpatient visits are paid at 100% of HMC/APS contracted rates after $25 copay ($12.50 copay for group sessions) limited to a maximum of 30 outpatient visits. Inpatient care is paid at 75% after $250 copay per admission. There is a maximum of $5,000 of out-of-pocket expense per year. There is a lifetime maximum of $25,000 for chemical dependency treatment (inpatient and outpatient combined). There is a maximum of 60 days per calendar year (120 days per lifetime) for inpatient care for mental health. AB88 illnesses are covered as any other office visits and/or hospitalization. The limits on days or visits do not apply.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs, except Injectables</td>
<td>See the Prescription Drugs section (below), and the Injectables (except Insulin) section (above).</td>
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</tr>
</tbody>
</table>
A list of services that are covered under the Indemnity and Prepaid Dental programs. Services not listed in the schedule are not covered; the participant is responsible for the cost of all such services.

**Prepaid Plans**

100% after required member copayments. In addition to specified copayments, you may also be responsible for items/services not covered by the prepaid plan including porcelain surcharges for crowns on some teeth.

Dental coverage is voluntary and an additional monthly contribution is required ($87.00 effective January 1, 2011).

**Maintenance Drugs**

Medication for Hypertension, High Cholesterol, Diabetes control drugs (including related supplies), Osteoporosis, Glaucoma and Asthma (Including related supplies), are considered Maintenance Drugs.

If you are taking a medication for one of the above conditions but it is not on the enclosed list, please check with Prescription Solutions at 800-797-9791 to determine whether your medication is considered a Maintenance Drug.

**Dental**

100% after required member copayments. In addition to specified copayments, you may also be responsible for items/services not covered by the prepaid plan including porcelain surcharges for crowns on some teeth.
Exclusions and limitations

HMOs

The following are not covered under HMOs:
- Any services not authorized by the HMO; any service or supply not considered medically necessary; work-related conditions; dental care; convalescent or custodial care; supplies or services furnished by the U.S. government or any agency thereof; medical care for which a third party may be liable unless costs are reimbursed by the third party; and medical treatment or care by a relative. Charges for services covered under an HMO are not eligible for reimbursement under the Indemnity PPO Medical Plan.

Indemnity PPO Medical Plan

The following are not covered under the Indemnity PPO Medical Plan:
- Any service or supply not considered Medically Necessary; work-related conditions; convalescent or Custodial Care; dental care; supplies or services furnished by the U.S. government or any agency thereof or furnished at the expense of same; conditions resulting from warfare or invasion; supplies or services not prescribed by a doctor; cosmetic surgery except to repair damage caused by accident; any condition where there exists no injury or illness; Experimental or Investigational surgery; medical treatment or care by a relative; transsexual surgery; reversal of voluntary sterilization and certain infertility services. Third-party liability benefits must be assigned to the Fund, not to exceed the amount payable by the Fund. Charges for services covered under an HMO are not eligible for reimbursement under the Indemnity PPO Medical Plan. (These exclusions and limitations are not all-inclusive. See the Indemnity PPO Medical Plan description in this book for more detail.)

This booklet is only a summary of Plan Benefits, exclusions and limitations. In case of any difference between this booklet and the official Plan documents, the official Plan documents will prevail.