**NORTHERN CALIFORNIA SOFT DRINK INDUSTRY AND TEAMSTERS HEALTH AND WELFARE TRUST**
**COMPARISON OF BASIC INDEMNITY, ENHANCED INDEMNITY, AND KAISER PERMANENTE PLANS**

| BENEFIT | BASIC INDEMNITY PLAN | | ENHANCED INDEMNITY PLAN | | KAISER PERMANENTE PLAN |
|---|---|---|---|---|---|
| | Contract Provider | Non-Contract Provider | Contract Provider | Non-Contract Provider | Kaiser Permanente Providers |
| Medical | Provided by Anthem Blue Cross | | Provided by Anthem Blue Cross | | Provided by Kaiser Permanente |
| Calendar Year Maximum | Unlimited | | Unlimited | | Unlimited - using Kaiser Permanente Providers |
| Out-Of-Pocket Maximum Protection per calendar year | $4,000 per person / $8,000 per family | Unlimited | $1,500 per person / $4,500 per family | $5,000 per person / $15,000 per family | $1,500 per person / $3,000 per family |
| Calendar Year Deductible | $3,000 per person / $6,000 per family | $9,000 per person / $18,000 per family | $200 per person / $400 per family | $200 per person / $400 per family | $200 Per person / $400 per family |
| Hospital Inpatient | If prior authorization in not obtained from Anthem Blue Cross, benefits will be reduced by 10% | | If prior authorization in not obtained from Anthem Blue Cross, benefits will be reduced by 10% | | |
| Room and Board | 60% of contract rate** | 40% of semi-private room rate** | 90% of contract rate** | 70% of semi-private room rate** | 90% per admission** |
| Intensive Care | 60% of contract rate** | 40% of intensive care room rate, not to exceed twice semi-private rate** | 90% of contract rate** | 70% of intensive care room rate, not to exceed twice semi-private rate** | 90% per admission** |
| Miscellaneous Hospital Charges | 60% of contract rate** | 40% of UCR** | 90% of contract rate** | 70% of UCR** | 90% per admission** |
| Out of Area Provider Charges | Not applicable | 60% of UCR for treatment within 24 hours of accident** | Not applicable | 90% of UCR for treatment within 24 hours of accident** | Covered for emergencies only |
| Emergency Room | 60% of contract rate for treatment within 24 hours of accident ** | 60% of UCR for treatment within 24 hours of accident.** | 90% of contract rate for treatment within 24 hours of accident ** | 90% of UCR for treatment within 24 hours of accident.** | Pays 90% per visit. |
| Ambulance | 60% of contract rate** | 40% of UCR** | 90% of contract rate** | 70% of UCR** | $150 per trip ** |
| Surgery | | | | | |
| Inpatient | 60% of contract rate ** | 40% of UCR ** | 90% of contract rate ** | 70% of UCR ** | 90% per admission ** |
| Outpatient | 60% of contract rate ** | 40% of UCR ** | 90% of contract rate ** | 70% of UCR ** | 90% per procedure ** |
| Anesthesia | 60% of contract rate ** | 40% of UCR ** | 90% of contract rate ** | 70% of UCR ** | 90% per procedure ** |

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| BENEFIT | BASIC INDEMNITY PLAN | | ENHANCED INDEMNITY PLAN | | KAISER PERMANENTE PLAN |
|---|---|---|---|---|---|
| | Contract Provider | Non-Contract Provider | Contract Provider | Non-Contract Provider | Kaiser Permanente Providers |
| Physician Care<br>Office, hospital and home visits (includes chiropractor & podiatrist) | 60% of contract rate ** | 40% of UCR ** | 90% of contract rate ** | 70% of UCR ** | Hospital provided without charge. Office calls - $25 copay charge. Chiropractors are not covered. |
| Out of Area Physician Charges | Not applicable | 40% of UCR ** | Not applicable | 70% of UCR ** | Provided at a $50 copayment for life threatening emergency care, as defined by Kaiser (waived if admitted) |
| Routine Physical Exams including preventive care | Provided without charge | 40% of UCR | Provided without charge | 70% of UCR | Provided without charge |
| Newborn Nursery Care | Provided without charge | 40% of UCR | Provided without charge | 70% of UCR | Provided without charge |
| Well Child Care / Immunizations to age 18 | Provided without charge | 40% of UCR to age 5 | Provided without charge | 70% of UCR to age 5 | Provided without charge |
| Diagnostic X-ray & Lab | 60% of contract rate ** | 40% of UCR ** | 90% of contract rate ** | 70% of UCR ** | $10 copay per encounter |
| Maternity Care / Midwife | Payable as any other illness, for eligible employees and dependent wives only | | Payable as any other illness, for eligible employees and dependent wives only | | Maternity: $25 office visit copay; pays 90% per admission ** Midwife: Covered at Kaiser Permanente facilities where available ** |
| Hospice Care | 60%** of allowable expenses; must be authorized by Anthem Blue Cross (800) 274-7767 | | 90%** of allowable expenses; must be authorized by Anthem Blue Cross (800) 274-7767 | | Pays 90% of care ** |
| Home Health Care | 60%** of allowable expenses; must be authorized by Anthem Blue Cross (800) 274-7767, and certified as medically necessary by attending physician | | 90%** of allowable expenses; must be authorized by Anthem Blue Cross (800) 274-7767, and certified as medically necessary by attending physician | | Pays 90% ** if prescribed by Plan Physician for part-time, intermittent visit of RN |
| Mental Health/Psychiatric Care | If prior authorization in not obtained from Anthem Blue Cross, benefits will be reduced by 10% | | If prior authorization in not obtained from Anthem Blue Cross, benefits will be reduced by 10% | | |
| Inpatient | 60% of contract rate ** | 40% of UCR ** | 90% of contract rate ** | 70% of UCR ** | Pays 90% per Admission** |
| Outpatient | 60% of contract rate ** | 40% of UCR ** | 90% of contract rate ** | 70% of UCR ** | $25 copay per visit - individual; $15 copay per visit group session |
| Organ Transplant | One Transplant Procedure; only those transplants listed below are covered. Pays 60% per Transplant | | One Transplant Procedure; only those transplants listed below are covered. Pays 90% per Transplant | | Pays 90% per procedure** |
| Including Incidental Expenses, Transportation, Lodging & meals, Private Nursing & Donor Expenses | Bone Marrow, Liver, Kidney<br>Lung, Pancreas, Heart<br>Heart/Lung | | Bone Marrow, Liver, Kidney<br>Lung, Pancreas, Heart<br>Heart/Lung | | (Experimental or non-human transplants not covered) |
| Alcohol and Drug Rehabilitation Inpatient | If prior authorization in not obtained from TAP, benefits will be reduced by 10% | | If prior authorization in not obtained from TAP, benefits will be reduced by 10% | | |
| | 60% of TAP contract rate ** | 40% of UCR ** | 90% of TAP contract rate ** | 70% of UCR ** | Detoxification treatment is provided through Kaiser. |
| Outpatient | 60% of TAP contract rate ** | 40% of UCR ** | 90% of TAP contract rate ** | 70% of UCR ** | Outpatient Individual Therapy - $25 copayment |

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| BENEFIT | BASIC INDEMNITY PLAN | | ENHANCED INDEMNITY PLAN | | KAISER PERMANENTE PLAN |
|---|---|---|---|---|---|
| | Contract Provider | Non-Contract Provider | Contract Provider | Non-Contract Provider | Kaiser Permanente Providers |
| Prescription Drugs | Prescription Drugs Provided through Optum Rx | | Prescription Drugs Provided through Optum Rx | | Prescription Drugs Provided through Optum Rx |
| Out-Of-Pocket Maximum Protection per calendar year | $2,600 per person / $ 5,200 for family | | $5,100 per person / up to $10,200 for family | | $5,100 per person / up to $10,200 for family |
| Calendar Year Deductible | $1,500 per person / $3,000 per family | | None | | None |
| Generic Drugs - Retail | 30% copay - 30 day supply** | | $5 copay - 30 day supply | | $5 copay - 30 day supply |
| Mail Order | 30% copay - 90 day supply** | | $10 copay - 90 day supply | | $10 copay - 90 day supply |
| Formulary Brand Name - Retail | 40% copay - 30 day supply** | | $20 copay - 30 day supply | | $20 copay - 30 day supply |
| Mail Order | 40% copay - 90 day supply** | | $40 copay - 90 day supply | | $40 copay - 90 day supply |
| Non Formulary Brand - Retail | 40% copay - 30 day supply** | | $45 copay - 30 day supply | | $45 copay - 30 day supply |
| Mail Order | 40% copay - 90 day supply** | | $90 copay - 90 day supply | | $90 copay - 90 day supply |
| Vision Care | VSP Provider | Non-VSP Provider | VSP Provider | Non-VSP Provider | Kaiser |
| Vision Exam | 100% of charges, once every 12 months | $40 benefit | 100% of charges, once every 12 months | $40 benefit | Eye examination for corrective |
| Lenses | 100% of charges, once every 12 months | $40 Single / $60 Bifocals/$80 Trifocals/$125 Lenticular lenses | 100% of charges, once every 12 months | $40 Single / $60 Bifocals/$80 Trifocals/$125 Lenticular lenses | Lenses are provided without charge from Kaiser. |
| Frames | 100% of charges, once every 24 months, if needed | $45 benefit | 100% of charges, once every 24 months, if needed | $45 benefit | Corrective lenses, eyeglasses, and contact lenses are not covered. Members can receive reimbursement from VSP under the Non-VSP schedule. |
| Contact Lenses | Covered if approved by VSP, otherwise an allowance in lieu of other benefits | $210 - Necessary / $105 - cosmetic | Covered if approved by VSP, otherwise an allowance in lieu of other benefits | $210 - Necessary / $105 - cosmetic | |

** Deductible applies.
UCR - Usual, Customary and Reasonable Charge. UCR applied to all charges except Preferred provider charges under the Indemnity Plan.

This summary is intended as a guide to assist you in comparing Plans. Please refer to the Plan booklets for specific terms, benefits, exclusions and limitations. If you would like to request a Summary of Benefits and Coverage on a particular plan described above, please call the Fund at (855) 690-7250.