

TEAMSTERS AND FOOD EMPLOYERS SECURITY TRUST FUND COMPARISON OF BENEFITS

Active Participants & Non-Medicare Retirees (Some benefits in this comparison apply to Active Participants only, as noted)

The following information is a brief summary of the medical benefits provided through the Fund.

Exact benefits are paid according to the terms, exclusions and conditions of the applicable medical policy, and the Plan Document.

KAISER FOUNDATION HEALTH PLAN	HEALTH NET	
Employees and Dependents – Provided without charge.	Employees and Dependents – Provided without charge.	
Employees and Dependents – Provided without charge.	Employees and Dependents – Provided without charge.	
Employees and Dependents – \$10 per procedure.	Employees and Dependents – Provided without charge.	
Employees and Dependents – \$10 per visit. Physical therapy, X-ray & lab – \$0 co-pay	Employees and Dependents – Provided without charge.	
Employees and Dependents – Provided without charge.	Employees and Dependents – Provided without charge. Infertility injections 50% co-insurance.	
Employees and Dependents – Covered in full within 30 miles of the nearest Kaiser Foundation Medical Facility when authorized.	Employees and Dependents – Provided without charge.	
Employees and Dependents – Provided without charge up to 100 days per benefit period.	Employees and Dependents – Provided without charge up to 100 days.	
Employees and Dependents – Provided without charge.	Employees and Dependents – Provided without charge. Except Elective Abortions \$150 co-payment Except sterilization for males \$ 50 co-payment Except sterilization for females \$150 co-payment	
Employees and Dependents – \$10 per visit.	Employees and Dependents – Provided without charge.	
Employees and Dependents – Provided without charge.	Employees and Dependents – Provided without charge.	
Employees and Dependents – \$10 per visit.	Employees and Dependents – \$10 co-payment.	
Employees and Dependents – Provided without charge.	Employees and Dependents – Provided without charge.	
Employees and Dependents – \$10 per visit. Eye examinations for glasses are included and are also provided at \$10 per visit. (Immunizations are provided at NO charge. Other injected medications are provided at reasonable rates.)	Employees and Dependents – Provided at \$10 co-payment. Eye examinations for glasses: included and also provided at \$10 co-payment. (Specified immunizations and injections are provided at \$10 co-payment.) In fertility services are subject to payment. Actives only. Does not apply to retirees.	
Employees and Dependents – When prescribed by Plan Physician, care will be directed by Home Health Committee. Must be services which are medically necessary and can be safely and effectively provided in a Member's home. Provided to Members substantially confined to home but does not include custodial care, homemaker care or care more appropriately provided in a Plan Medical Office, Hospital or Skilled Nursing Facility.	Employees and Dependents – \$20 co-payment per visit.	
Employees and Dependents – \$10 per visit.	Employees and Dependents – Services of a podiatrist will be provided if determined medically necessary by primary care physician. \$10 co-payment per visit.	
Inpatient psychiatric care (up to 45 days per calendar year). Outpatient visits up to a total of 20 individual therapy visits per calendar year. Up to 20 additional group therapy visits that meet medical group criteria in the same calendar year.	Employees and Dependents – Provided at no charge. Employees and Dependents – \$10 per visit. Employees and Dependents – \$5 per visit.	Mental Health coverage is excluded except for detox treatment only. Active participants must call Health Manager at (800) 431-5036. Actives & non-Medicare Health Net enrollees - for benefits see the Mental Health & Chemical Treatment Benefit under the Indemnity Plan.
Not covered.	Not covered.	
Covered within benefits as outlined.	Covered within benefits as outlined.	
Not applicable.	Not applicable.	
\$10,000.00 - Provided by the Fund.	\$10,000.00 - Provided by the Fund.	
\$10,000.00 - Provided by the Fund.	\$10,000.00 - Provided by the Fund.	
Services provided only at Kaiser Foundation Hospitals and Permanente Medical Centers by doctors affiliated with the Plan.	Services must be provided at Health Net Medical facilities by assigned doctors associated with the Plan. Community throughout the area are used.	
Employees and Dependents – \$35 per visit (waived if admitted directly to the hospital). Employees and Dependents – Medically necessary services for conditions that require immediate medical attention. Emergency care should be obtained from Kaiser facilities if possible. If Plan Hospital is not available, care obtained from non-Plan providers is also covered.	Employees and Dependents – If you are ill or become injured and require emergency care from a physician or hospital, Health Net, Health Plan will pay reasonable charges for such care under the following conditions:	
NON-PLAN FACILITY: Provided for emergency treatment required before your condition permits transfer to a Plan Facility. Kaiser must be notified within 48 hours after care begins (or as soon as reasonably possible.) Benefit applies to care that is a covered service under Health Plan Service Agreement. WITHIN SERVICE AREA: Benefits provided for immediate care needed as a result of unforeseen illness or injury if delay to reach Plan Facility would result in death, serious disability or significant jeopardy to condition. OUTSIDE SERVICE AREA: Benefits provided for immediate care needed as a result of unforeseen illness or injury if services could not be delayed until Member could reach a Plan Hospital or Medical Office in Service Area. LIMITATIONS ON SERVICES RECEIVED FROM NON-PLAN PHYSICIANS OR FACILITIES: Any other health care coverage program is payable before Kaiser Permanente benefit for emergency services at a non-Plan facility is payable. Kaiser retains right to recover payment of benefits covered by other plans. Payments are subject to reduction if injury occurred through the fault of someone else.	WITHIN SERVICE AREA: Reasonable charges will be covered after a \$50 co-payment for hospital emergency services that Health Net is contacted within 48 hours after care is sought and authorized the emergency care. Co-payment emergency results in hospitalization. OUTSIDE SERVICE AREA: Emergency room and urgent care visits will be covered with a \$50.00 co-payment/wait. Unexpected premature delivery is covered but normal delivery is not.	
(a) Employee's wife or husband. (b) Employee's unmarried children (including any step-children and legally adopted children), under 19 years of age. (c) Employee's unmarried children over 19 years of age attending school full-time (12 units or more) thru age 25. (d) Coverage of an unmarried dependent child who attains the age of 19 may be continued while he or she is incapable of self-support because of mental retardation or physical handicap and chiefly dependent upon subscriber or his spouse for support & maintenance.	(a) Employee's wife or husband (b) Employee's unmarried children (including any step-children or legally adopted children) under 19 years of age or children under 25 years of age attending an educational institution. (c) Unmarried children over 19 years of age who are wholly dependent on you, reside with you and are incapable of self-support due to mental retardation or physical handicap that existed prior to age 19.	
EXCLUSIONS: • Services covered by Workers' Compensation or care that is required to be provided only by a government agency. • Services which, by law, an employer is required to provide. • Services for military service-connected conditions when care is reasonably available from the Veterans Administration. • Physical exams and related services related to employment, licensing or court orders. • Dental services except for medically necessary care. • Services related to conception by artificial means. Artificial insemination is covered except for donor semen, donor eggs and services related to their procurement and storage. • Services to reverse voluntary, surgically induced infertility. • Chiropractic Services. • Experimental or investigation services. • Cosmetic services plastic surgery or other services performed primarily to improve appearance and that will not result in significant improvement in physical functions. Exclusion does not apply to covered services for correction of disfigurement from injury or medical	EXCLUSIONS: • Care not authorized by a member Physician • Cosmetic or transsexual surgery • Reversals of voluntary surgically induced infertility • Experimental or investigative procedures • Routine physical exams for licensing, insurance, employment, camp or other non-preventive purposes • Dental services (limited) • Long term physical occupational speech therapy • Private duty nursing • Private rooms • Outpatient prescription drugs • Contraceptive devices	