

**SAN FRANCISCO ELECTRICAL WORKERS RETIREE HEALTH & WELFARE PLAN**  
**IBEW LOCAL 6**  
**2009-2010 HEALTH MAINTENANCE ORGANIZATIONS COMPARISON OF BENEFITS SUMMARY**

COVERAGE FEATURES	KAISER NON-MEDICARE	KAISER PERMANENTE SENIOR ADVANTAGE (Medicare HMO Plan)	BLUE SHIELD NON MEDICARE
<b>CHOICE OF PROVIDERS</b>	Must use Kaiser facilities and providers	Must use Kaiser facilities and providers	Must use Health Plan provider
<b>PLAN MAXIMUMS</b>	No plan maximum	No plan maximum	No plan maximums.
<b>OUT OF POCKET MAXIMUMS</b>	\$1,500 individual \$3,000 family	\$1,500 individual \$3,000 family	\$2,000 individual \$4,000 two-party \$6,000 family
<b>HOSPITAL CONFINEMENT</b> <i>Room and board, surgery, anesthesia and miscellaneous</i>	No charge	No charge	\$100 per confinement
<b>DOCTOR VISITS</b> Office Hospital	\$20 per visit No charge	\$20 per visit No charge	\$25 per visit No charge
<b>OUTPATIENT LAB &amp; X-RAYS</b>	No charge	No charge	No charge
<b>OUTPATIENT SURGERY</b>	No charge	No charge	\$50 per surgery
<b>PREVENTATIVE HEALTH CARE</b> <i>(Routine checkups, well baby care, immunizations, pap smears, etc.).</i>	\$20 per visit \$5 Well Baby preventive care visits (0-23 months)	\$20 per visit	No charge  No charge for well baby.
<b>AMBULANCE SERVICES</b>	No charge if authorized and medically necessary.	No charge if authorized and medically necessary.	No charge
<b>MATERNITY CARE</b> Mother's Hospital Expenses  Mother's Expenses  Newborn Care	No Charge  No charge Inpatient Care \$20 Prenatal Care & First postpartum office visit  No charge in hospital. Newborns must be <b>enrolled within 31 days of birth.</b>	No Charge  No charge Inpatient Care \$20 Prenatal Care and First postpartum office visit  No charge in hospital. Newborns must be <b>enrolled within 31 days of birth.</b>	No Charge  No Charge  No charge in hospital <b>if enrolled within 31 days of birth.</b>
<b>EYE EXAMINATIONS/GLASSES</b> <b>Vision Service Plan:</b> \$10 co-payment Examinations: every 12 months Lenses: every 12 months Frames: every 24 months	Covered through Vision Service Plan.  \$20 co-payment eye examinations only through Kaiser.	Covered through Vision Service Plan.  \$20 co-payment for examinations Kaiser provides \$150 allowance for one pair every two years. Contacts in lieu of glasses if medically necessary.	Covered through Vision Service Plan.
<b>MENTAL HEALTH</b> (Effective 2/1/10 benefits will be brought into parity with other medical benefits provided under the plan as required by the Federal Mental Health Parity Act)  Outpatient  Inpatient	  \$20 co-pay up to 20 visits per calendar year. (Severe mental illnesses covered as any other condition)  Hospital covered in full up to 30 days per year.	  \$20 co-pay for unlimited visits. (Severe mental illnesses covered as any other condition)  Hospital covered in full up to 45 days per year in addition to 190 plan days per lifetime as covered by Medicare.	[Coverage through PacifiCare Behavioral Health (PBH). All services must be pre-authorized by PBH; eligible participants are required to utilize network facilities and providers for mental health and substance abuse treatment]  \$0 Co-pay; 30 visit limit (Severe mental illness-\$0 Co-pay; unlimited visits)  100% coverage up to 30 days per calendar year after any applicable co-pay.

COVERAGE FEATURES	KAISER NON-MEDICARE	KAISER SENIOR ADVANTAGE	BLUE SHIELD NON-MEDICARE
<p><b>CHEMICAL DEPENDENCY</b> (Alcohol or drug abuse)</p> <p>(Effective 2/1/10 benefits will be brought into parity with other medical benefits provided under the plan as required by the Federal Mental Health Parity Act)</p>	<p>No Charge for Inpatient Detox. \$20 Outpatient Visits \$5 Outpatient Group Visits \$100 Transitional Residential Recovery Services (up to 60 days per calendar year not to exceed 120 days in any 5 year period)</p> <p><u>Alternatively, benefits are provided through the PacifiCare Behavioral Health substance Abuse Program (see description under SELF-FUNDED PPO)</u></p>	<p>No Charge for Inpatient Detox. \$20 Outpatient Visits \$5 Outpatient Group Visits \$100 Transitional Residential Recovery Services (up to 60 days per calendar year not to exceed 120 days in any 5 year period)</p> <p><u>Alternatively, benefits are provided through the PacifiCare Behavioral Health substance Abuse Program (see description under SELF-FUNDED PPO)</u></p>	<p>All benefits provided through the PacifiCare Behavioral Health Substance Abuse Program.. \$25,000 Annual Maximum; \$35,000 Lifetime Maximum \$0 Co-pay outpatient; 100% covered inpatient. <u>Blue Shield covers medical acute detoxification the same as medical – \$100 per confinement.</u></p> <p><u>Alternatively, benefits are provided through the PacifiCare Behavioral Health substance Abuse Program (see description under SELF-FUNDED PPO)</u></p>
<p><b>MEMBER ASSISTANCE PROGRAM (MAP)</b> (Available to all household members)</p>	<p>(Coverage through PacifiCare Behavioral Health) 3 visits/\$0 co-pay: Resource Referrals – Childcare, Eldercare, Legal, Financial, Emotional Issues, Work Issues, Addiction Treatment</p>	<p>(Coverage through PacifiCare Behavioral Health) 3 visits/\$0 co-pay: Resource Referrals – Childcare, Eldercare, Legal, Financial, Emotional Issues, Work Issues, Addiction Treatment</p>	<p>(Coverage through PacifiCare Behavioral Health) 3 visits/\$0 co-pay: Resource Referrals – Childcare, Eldercare, Legal, Financial, Emotional Issues, Work Issues, Addiction Treatment</p>
<p><b>PHYSICAL THERAPY</b></p>	<p>\$20 co-payment (short term)</p>	<p>\$20 co-payment (short term)</p>	<p>\$25 per visit (short term)</p>
<p><b>PRESCRIPTION DRUGS</b></p>	<p>\$10 (generic) \$30 (brand named) per prescription or refill at Kaiser Pharmacies up to a 30 day supply.</p>	<p>\$10 (generic) \$25 (brand named) per prescription or refill at Kaiser Pharmacies up to a 30 day supply.</p>	<p>\$15 (generic) \$30 (brand named) per prescription or refill for a 30-day supply. \$30 (generic) \$60 (brand named) per prescription or refill for a 90-day supply of mail order prescriptions. Home Self-injectable 20% up to \$100 co-pay maximum per prescription</p>
<p><b>PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT</b></p>	<p>No Charge.</p>	<p>No Charge.</p>	<p>Prosthetic &amp; Orthotic – equipment &amp; devices no charge with authorization. Durable medical equipment – no charge up to \$5,000 maximum per calendar year.</p>
<p><b>EMERGENCY CARE AND OUT OF SERVICE AREA</b> (Outside of Plan facilities)</p>	<p>\$50 co-pay, waived if admitted. Worldwide coverage for Urgent and Emergency services. Follow-up Visits covered at Kaiser facility.</p>	<p>\$50 co-pay, waived if admitted. Worldwide coverage for Urgent and Emergency services. Follow-up Visits covered at Kaiser facility.</p>	<p>\$50 co-pay, waived if admitted. Routine care not covered.</p>
<p><b>DENTAL COVERAGE</b></p>	<p>Covered by Delta Dental</p>	<p>Covered by Delta Dental</p>	<p>Covered by Delta Dental</p>
<p><b>SPECIAL NOTES</b></p> <p>Your eligible dependents are: Lawful Spouse, Registered Domestic Partner, Unmarried children through age 18, Unmarried children ages 19 through 24 if full time students.</p>	<p><u>Allergy testing:</u> \$20 co-payment /treatment \$3 co-pay Injections <u>Chiropractic:</u> Chiropractic covered at \$15 co-pay up to 30 visits in the calendar year. <u>Home Health:</u> Skilled nursing visits on intermittent basis - no charge when prescribed. <u>Facility:</u> Skilled Nursing/ 100 days per benefit period no charge if authorized.</p>	<p><u>Allergy testing:</u> \$20 co-payment /treatment \$3 co-pay Injections <u>Chiropractic:</u> Chiropractic covered at \$15 co-pay up to 30 visits in the calendar year. <u>Home Health:</u> Skilled nursing visits on intermittent basis - no charge when prescribed. <u>Facility:</u> Skilled Nursing/100 days per benefit period no charge if authorized.</p>	<p><u>Allergy testing:</u> \$25 co-pay for allergy testing, serum included. <u>Chiropractic:</u> Chiropractic and Acupuncture services not covered. <u>Facility:</u> Skilled nursing/100 days per year no charge if authorized. <u>Infertility treatment:</u> Testing paid at 50% of allowed charges. <u>Home health care:</u> Maximum of 100 days per calendar year.</p>

**NOTE: This comparison of benefit coverage is intended only as a general description of the principle features of the benefit plans. Each Plan's benefit booklet should be consulted for additional information.**