

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

| COVERED FEATURES   | COMPREHENSIVE MEDICAL COVERAGE  | HEALTH MAINTENANCE ORGANIZATIONS   |  |
|--|---|--|--|
|  | SELF-FUNDED PPO Coverage Worldwide  | KAISER PERMANENTE  | BLUE SHIELD  |
| <b>CHOICE OF PROVIDERS</b>   | Choose any physician or hospital. Reduced charges available from PPO hospital and physician networks.   | Must use Kaiser Permanente facilities and providers.   | Must use Health Plan Providers.  |
| <b>PLAN MAXIMUMS</b>   | \$750,000 per calendar year per family member.<br>\$2,000,000 plan max. per family member.  | No plan maximum.   | No plan maximum.   |
| <b>OUT-OF-POCKET MAXIMUMS</b>  | <b>In Network Providers:</b> All benefits paid at 80% after satisfying deductible of \$100 per person/\$200 family. All covered benefits paid at 100% after \$1,500 per person of covered expenses in a calendar year.<br><b>Out of Network Providers:</b> All benefits paid at 60% after satisfying deductible of \$100 per person/\$200 family. All covered benefits paid at 80% after \$1,500 per person of covered expenses in a calendar year. | \$1,500 Individual<br>\$3,000 Family   | \$2,000 individual<br>\$4,000 two-party<br>\$6,000 family  |
| <b>HOSPITAL CONFINEMENT</b><br>Room and Board, surgery, anesthesia and miscellaneous                           | Pays 80% after deductible (60% out of network)  | No charge  | \$100 per confinement  |
| <b>DOCTOR VISITS</b><br>Office<br>Hospital   | Pays 80% after deductible (60% out of network)<br>Pays 80% after deductible (60% out of network)  | \$20 per visit<br>No charge  | \$25 per visit<br>No charge  |
| <b>OUTPATIENT LAB &amp; X-RAYS</b>   | Pays 80% after deductible (60% out of network)  | No charge  | No charge  |
| <b>OUTPATIENT SURGICAL &amp; EMERGENCY ROOM SVCS</b>   | First \$5,000 paid at 100% (in network), 80% (Out of network) then subject to annual deductible and in-network (80%) and out of network (60%) co-insurance.   | No charge  | \$50 per surgery   |
| <b>PREVENTATIVE HEALTH CARE</b><br><i>(Routine check-ups, well baby care, immunizations, pap smears, etc.)</i> | Pays 80% after deductible (60% out of network) for:<br>Annual Physical- up to \$300 maximum<br>Preventative care and immunizations<br>Pays 100% for:<br>Mammograms, Pap Smears & Pelvic Exams,<br>Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy, Prostate Cancer Screening   | \$20 per visit<br>\$5 Well Baby preventive care visits (0-23 Months)   | No Charge<br>No charge for well baby.  |
| <b>AMBULANCE SERVICES</b>  | Pays 80% after deductible (60% out of network) if required to move patient from place of injury or illness to nearest hospital equipped to provide necessary care.  | No charge if authorized and medically necessary  | No charge  |
| <b>MATERNITY CARE</b><br>Mother's Hospital Expenses<br><br>Mother's Expenses – Office<br>Newborn Care          | <b>(Members &amp; Spouses/Domestic Partners only)</b><br>Same as hospital confinement shown above for 48 hours following vaginal delivery and 96 hours following deliver by caesarian section.<br>Pays 80% after deductible. (60% out of network)<br>Covered while mother is confined   | No charge<br><br>\$20 Prenatal Care & First Post Partum Visit<br>No charge in hospital. Newborns must be <b>enrolled within 31 days of birth.</b>  | No charge<br><br>No charge<br>No charge in hospital <b>if enrolled within 31 days of birth</b>   |
| <b>EYE EXAMINATIONS</b><br><b>EYE GLASSES</b>  | Covered by Vision Service Plan. \$10 co-payment; Examination and lenses provided every 12 months; new frames available every 24 months.   | \$20 per visit (Exams Only) through Kaiser<br>Covered by Vision Service Plan. \$10 co-payment; Examination and lenses provided every 12 months; \$200 new frame allowance available every 24 months. | Covered by Vision Service Plan. \$10 co-payment; Examination and lenses provided every 12 months; \$200 new frame allowance available every 24 months. |

| COVERED FEATURES  | COMPREHENSIVE MEDICAL COVERAGE   | HEALTH MAINTENANCE ORGANIZATIONS  |   |
|---|--|---|---|
|   | SELF-FUNDED PPO  | KAISER PERMANENTE   | BLUE SHIELD   |
| <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)<br>Outpatient<br><br>Inpatient                       | [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]<br><br>\$0 Co-pay; 30 visit limit<br>Severe mental illness-\$0 Co-pay; unlimited visits;<br><br>100% coverage up to 30 days per calendar year after any applicable admission fees or co-pay. | \$20 up to 20 visits per calendar year. (No limits for Mental Health Parity diagnosis)<br>\$10 per Group Visits up to 20 per year<br><br>Up to 45 days per benefit period (No limits for Mental Health Parity diagnosis)  | [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]<br><br>\$0 Co-pay; 30 visit limit<br>Severe mental illness-\$0 Co-pay; unlimited visits;<br><br>100% coverage up to 30 days per calendar year after any applicable admission fee. |
| <b>CHEMICAL DEPENDENCY</b><br><i>(Alcohol and Drug dependency)</i><br><br>(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) | All benefits, including detox, provided through the PacifiCare Behavioral Health Substance Abuse Program. \$25,000 Annual Maximum; \$35,000 Lifetime Maximum<br>\$0 Co-pay; covered at 100%  | \$20 per Visit. - Outpatient visit through Chemical Dependency Recovery Program at Kaiser of Behavioral Medicine Department.<br>\$5 Group Visits.<br>\$100 Transitional Residential services (up to 60 days per calendar year, not to exceed 120 days in any five year period.<br>\$0 Hospitalization covered for Detox from Kaiser.<br><u>Alternatively, benefits are provided through the PacifiCare Behavioral Health Substance Abuse Program (See description under SELF-FUNDED PPO).</u> | All benefits provided through the PacifiCare Behavioral Health Substance Abuse Program. \$25,000 Annual Maximum; \$35,000 Lifetime Maximum<br>\$0 Co-pay outpatient; 100% covered patient<br><br><u>Blue Shield covers medical acute detoxification the same as medical – no charge for inpatient hospitalization.</u>  |
| <b>PHYSICAL THERAPY</b>   | Pays 80% after deductible (60% out of network). Claims subject to peer review for medical necessity and determination of appropriate treatment.  | \$20 Co-pay (short term)  | Short-term therapy \$25 copay.  |
| <b>MEMBER ASSISTANCE PROGRAM (MAP)</b><br><i>(Available to all household members)</i>   | (Coverage through PacifiCare Behavioral Health) 3 visits/\$0 co-pay: Resource Referrals – Childcare, Eldercare, Legal, Financial, Emotional Issues, Work Issues, Addiction Treatment   | (Coverage through PacifiCare Behavioral Health) 3 visits/\$0 co-pay: Resource Referrals – Childcare, Eldercare, Legal, Financial, Emotional Issues, Work Issues, Addiction Treatment  | (Coverage through PacifiCare Behavioral Health) 3 visits/\$0 co-pay: Resource Referrals – Childcare, Eldercare, Legal, Financial, Emotional Issues, Work Issues, Addiction Treatment  |
| <b>PRESCRIPTION DRUGS</b>   | Administered through RxAmerica. Individual responsible for 20% co-payment payable to pharmacy at time prescription is filled.<br>Note: Substantial savings may be obtained through the use of mail order prescription service.   | \$10 generic/\$30 brand named per prescription or refill at Kaiser Permanente Pharmacies up to a 30-day supply.   | \$15 (generic)/\$30 (brand named) per prescription or refill for a 30-day supply.<br>\$30 (generic) /\$60 (brand named) for a 90-day supply of mail order prescriptions.<br>Home Self-injectable 20% up to \$100 co-pay maximum per prescription  |
| <b>PROSTHETIC DEVICES &amp; DURABLE MEDICAL EQUIPMENT</b>   | Pays 80% after deductible (60% out of network). Rental of medical equipment, not to exceed the purchase price.   | No charge.  | Prosthetics & Orthotics equipment and devices no charge. Durable Medical Equip. no charge. \$5,000 maximum per calendar year.   |
| <b>EMERGENCY CARE AND OUT OF AREA SERVICE</b><br><i>(Outside of Plan facilities)</i>  | Coverage applies worldwide. Charges for certain emergency related treatment is covered under the \$5,000 in full in-patient Hospital benefit described above   | \$50 Co-pay. Worldwide coverage for urgent or emergency services. Follow-up and routine care covered at Kaiser facility. Waived if admitted directly to hospital.   | \$100 copay, waived if admitted. Routine care not covered.  |
| <b>DENTAL COVERAGE</b>  | Covered by Delta Dental.   | Covered by Delta Dental.  | Covered by Delta Dental   |
| <b>SPECIAL NOTES</b><br>Your eligible dependents are:<br>Lawful Spouse<br>Registered Domestic Partner<br>Unmarried children through age 18<br>Unmarried children ages 19 through 24 if full-time students                                 | Chiropractic & Acupuncture treatments covered as any other medical expense, limited to 30 visits per calendar year.<br>Indemnity payments are based on allowable charges.<br>Blood donations for your own surgery covered if physician recommends.   | Chiropractic covered at \$15 per visit, limited to 30 visits per benefit year. Acupuncture services are not covered.<br>\$20 per Visit Allergy and/or Testing<br>\$3 Allergy Injection Visits   | Chiropractic and Acupuncture services not covered. \$25 per visit for allergy testing, allergy serum is included. Home health care maximum of 100 visits per calendar year. Infertility testing paid at 50% of allowed charges.   |

“Year” means Calendar year unless otherwise indicated.

**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.