# SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN
# IBEW LOCAL 6
# 2010-2011 COMPARISON OF BENEFITS SUMMARY

| COVERED FEATURES | COMPREHENSIVE MEDICAL COVERAGE | HEALTH MAINTENANCE ORGANIZATIONS | |
|---|---|---|---|
| | **SELF-FUNDED PPO**<br>Coverage Worldwide | **KAISER PERMANENTE** | **BLUE SHIELD** |
| **CHOICE OF PROVIDERS** | 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. |
| **PLAN MAXIMUMS** | $750,000 per calendar year per family member.<br>$2,000,000 lifetime maximum per family member.<br>(Effective 2/1/11 no lifetime maximum). | No plan maximum. | No plan maximum. |
| **OUT-OF-POCKET MAXIMUMS** | **In Network Providers**: 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>**Out of Network Providers**: 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 |
| **HOSPITAL CONFINEMENT**<br>Room and Board, surgery, anesthesia and miscellaneous | Pays 80% after deductible (60% out of network) | No charge | $100 per confinement |
| **DOCTOR VISITS**<br>Office<br>Hospital | <br>Pays 80% after deductible (60% out of network)<br>Pays 80% after deductible (60% out of network) | <br>$20 per visit<br>No charge | <br>$25 per visit<br>No charge |
| **OUTPATIENT LAB & X-RAYS** | Pays 80% after deductible (60% out of network) | No charge | No charge |
| **OUTPATIENT SURGICAL & EMERGENCY ROOM SVCS** | 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. | $20 per procedure | $50 per surgery |
| **PREVENTATIVE HEALTH CARE**<br>*(Routine check-ups, well baby care, immunizations, pap smears, etc.)* | 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, 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. |
| **AMBULANCE SERVICES** | 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 |
| **MATERNITY CARE**<br>Mother's Hospital Expenses<br><br><br>Mother's Expenses – Office<br>Newborn Care | **(Members & Spouses/Domestic Partners only)**<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>$5 Prenatal Care & First Post Partum Visit<br>No charge in hospital. Newborns must be **enrolled within 31 days of birth.** | No charge<br><br>No charge<br>No charge in hospital **if enrolled within 31 days of birth** |
| **EYE EXAMINATIONS**<br>**EYE GLASSES** | 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<br>SELF-FUNDED PPO | HEALTH MAINTENANCE ORGANIZATIONS<br>KAISER PERMANENTE | <br>BLUE SHIELD |
|---|---|---|---|
| **MENTAL HEALTH** (Effective 2/1/10 benefits were brought into parity with other medical benefits provided under the plan as required by the Federal Mental Health Parity Act) | [Coverage through PacifiCare Behavioral Health (PBH). All services must be pre-authorized by PBH]<br>**In Network Providers**: 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>**Out of Network Providers**: 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. | Outpatient:<br>$20 co-pay for Individual Visits<br>$10 co-pay for Group Visits<br>Inpatient:<br>Hospital covered in full | [Coverage through PacifiCare Behavioral Health (PBH). All services must be pre-authorized by PBH]<br>**In Network Providers**: 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>**Out of Network Providers**: 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. |
| **CHEMICAL DEPENDENCY**<br>*(Alcohol and Drug dependency)*<br><br>(Effective 2/1/10 benefits were brought into parity with other medical benefits provided under the plan as required by the Federal Mental Health Parity Act) | [Coverage through PacifiCare Behavioral Health (PBH). All services must be pre-authorized by PBH]<br>**In Network Providers**: 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>**Out of Network Providers**: 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. | No Charge for inpatient Detox.<br>$20 Outpatient Visits.<br>$5 Outpatient Group Visits.<br><br>Alternatively, benefits are provided through the PacifiCare Behavioral Health Substance Abuse Program (See description under SELF-FUNDED PPO). | [Coverage through PacifiCare Behavioral Health (PBH). All services must be pre-authorized by PBH]<br>**In Network Providers**: 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>**Out of Network Providers**: 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. |
| **PHYSICAL THERAPY** | 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. |
| **MEMBER ASSISTANCE PROGRAM (MAP)**<br>*(Available to all household members)* | (Coverage through PacifiCare Behavioral Health)<br>3 visits/$0 co-pay: Resource Referrals – Childcare, Eldercare, Legal, Financial, Emotional Issues, Work Issues, Addiction Treatment | (Coverage through PacifiCare Behavioral Health)<br>3 visits/$0 co-pay: Resource Referrals – Childcare, Eldercare, Legal, Financial, Emotional Issues, Work Issues, Addiction Treatment | (Coverage through PacifiCare Behavioral Health)<br>3 visits/$0 co-pay: Resource Referrals – Childcare, Eldercare, Legal, Financial, Emotional Issues, Work Issues, Addiction Treatment |
| **PRESCRIPTION DRUGS** | Administered through CVS/Caremark. Individual responsible for 20% co-payment (maximum co-pay for generics of $7 retail and $17.50 mail order) payable to pharmacy at time prescription is filled. | $10 generic/$30 brand named per prescription or refill at Kaiser Permanente Pharmacies up to a 30-day supply.<br><br>$20 generic/$60 brand for a 90-day supply of mail–order only | $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 |
| **PROSTHETIC DEVICES & DURABLE MEDICAL EQUIPMENT** | Pays 80% after deductible (60% out of network). Rental of medical equipment, not to exceed the purchase price. | No charge in accord with Kaiser Permanente's durable medical equipment formulary guidelines | Prosthetics & Orthotics equipment and devices no charge. Durable Medical Equip. no charge.<br>$5,000 maximum per calendar year. |
| **EMERGENCY CARE AND OUT OF AREA SERVICE**<br>*(Outside of Plan facilities)* | 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.<br>Routine care not covered. |
| **DENTAL COVERAGE** | Covered by Delta Dental. | Covered by Delta Dental. | Covered by Delta Dental |
| **SPECIAL NOTES**<br>Your eligible dependents are:<br>- Lawful Spouse, Registered Domestic Partner, Unmarried children through age 18, Unmarried children ages 19 through 24 if full-time students.<br>- If no other group medical coverage (other than through a parent) is available Adult children ages 19 through 25 medical only. | 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.<br>$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.**