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

COVERAGE FEATURES	KAISER NON-MEDICARE	KAISER PERMANENTE SENIOR ADVANTAGE (Medicare HMO Plan)	BLUE SHIELD NON MEDICARE
CHOICE OF PROVIDERS	Must use Kaiser facilities and providers	Must use Kaiser facilities and providers	Must use Health Plan provider
PLAN MAXIMUMS	No plan maximum	No plan maximum	No plan maximums.
OUT OF POCKET MAXIMUMS	$1,500 individual $3,000 family	$1,500 individual $3,000 family	$2,000 individual $4,000 two-party $6,000 family
HOSPITAL CONFINEMENT *Room and board, surgery, anesthesia and miscellaneous*	No charge	No charge	$100 per confinement
DOCTOR VISITS Office Hospital	 $20 per visit No charge	 $20 per visit No charge	 $25 per visit No charge
OUTPATIENT LAB & X-RAYS	No charge	No charge	No charge
OUTPATIENT SURGERY	$20 per procedure	$20 per procedure	$50 per surgery
PREVENTATIVE HEALTH CARE *(Routine checkups, well baby care, immunizations, pap smears, etc.).*	$20 per visit $5 Well Baby preventive care visits (0-23 months)	$20 per visit	No charge No charge for well baby.
AMBULANCE SERVICES	No charge if authorized and medically necessary.	No charge if authorized and medically necessary.	No charge
MATERNITY CARE Mother's Hospital Expenses Mother's Expenses Newborn Care	 No Charge No charge Inpatient Care $5 Prenatal Care & First postpartum office visit No charge in hospital. **Newborns must be enrolled within 31 days of birth.**	 No Charge No charge Inpatient Care $5 Prenatal Care and First postpartum office visit No charge in hospital. **Newborns must be enrolled within 31 days of birth.**	 No Charge No Charge No charge in hospital. **Newborns must be enrolled within 31 days of birth.**
EYE EXAMINATIONS/GLASSES **Vision Service Plan:** $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 eyewear allowance for one pair every 24 months. Contacts in lieu of glasses if medically necessary.	Covered through Vision Service Plan.
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)	<u>Outpatient:</u> $20 co-pay for individual visits. $10 co-pay for group visits. <u>Inpatient:</u> Hospital covered in full.	<u>Outpatient:</u> $20 co-pay for individual visits. $10 co-pay for group visits. <u>Inpatient:</u> Hospital covered in full.	[Coverage through PacifiCare Behavioral Health (PBH). All services must be pre-authorized by PBH. **<u>In Network Providers:</u>** All benefits paid at 80% after satisfying deductible of $100 per person/ $200 per family. All covered benefits paid at 100% after $1,500 per person of covered expenses in a calendar year. **<u>Out of Network Providers:</u>** 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.

COVERAGE FEATURES	KAISER NON-MEDICARE	KAISER SENIOR ADVANTAGE	BLUE SHIELD NON MEDICARE
CHEMICAL DEPENDENCY (*Alcohol or drug abuse)* (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)	No Charge for Inpatient Detox. $20 Outpatient Visits $5 Outpatient Group Visits Alternatively, benefits are provided through the PacifiCare Behavioral Health substance Abuse Program (see description under SELF-FUNDED PPO)	No Charge for Inpatient Detox. $20 Outpatient Visits $5 Outpatient Group Visits 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. **In Network Providers:** All benefits paid at 80% after satisfying deductible of $100 per person/ $200 per family. All covered benefits paid at 100% after $1,500 per person of covered expenses in a calendar year. **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.
MEMBER ASSISTANCE PROGRAM (MAP) *(Available to all household members)*	(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
PHYSICAL THERAPY	$20 co-payment (short term)	$20 co-payment (short term)	$25 per visit (short term)
PRESCRIPTION DRUGS	$10 (generic) $30 (brand named) per prescription or refill at Kaiser Pharmacies up to a 30 day supply. $20 (generic) $60 (brand named) per prescription or refill for a 90 day supply of mail order only.	$10 (generic) $25 (brand named) per prescription or refill at Kaiser Pharmacies up to a 30 day supply. $20 (generic) $60 (brand named) per prescription or refill for a 90 day supply of mail order only.	$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
PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT	No Charge in accord with Kaiser Permanente's durable medical equipment formulary guidelines.	No Charge in accord with Kaiser Permanente's durable medical equipment formulary guidelines.	Prosthetic & Orthotic – equipment & devices no charge with authorization. Durable medical equipment – no charge up to $5,000 maximum per calendar year.
EMERGENCY CARE AND OUT OF SERVICE AREA (*Outside of Plan facilities*)	$50 co-pay, waived if admitted. Worldwide coverage for Urgent and Emergency services. Follow-up Visits covered at Kaiser facility.	$50 co-pay, waived if admitted. Worldwide coverage for Urgent and Emergency services. Follow-up Visits covered at Kaiser facility.	$50 co-pay, waived if admitted. Routine care not covered.
DENTAL COVERAGE	Covered by Delta Dental.	Covered by Delta Dental	Covered by Delta Dental
SPECIAL NOTES Your eligible dependents are: - Lawful Spouse, Registered Domestic Partner, Unmarried children through age 18 and Unmarried children ages 19 through 24 if full time students. - If no other group health coverage (other than through a parent) is available Adult children ages 19 through 25 medical only.	Allergy testing: $20 co-payment /treatment $3 co-pay Injections Chiropractic: Chiropractic covered at $15 co-pay up to 30 visits in the calendar year. Home Health: Skilled nursing visits on intermittent basis - no charge when prescribed. Facility: Skilled Nursing/ 100 days per benefit period no charge if authorized.	Allergy testing: $20 co-payment /treatment $3 co-pay Injections Chiropractic: Chiropractic covered at $15 co-pay up to 30 visits in the calendar year. Home Health: Skilled nursing visits on intermittent basis - no charge when prescribed. Facility: Skilled Nursing/100 days per benefit period no charge if authorized.	Allergy testing: $25 co-pay for allergy testing, serum included. Chiropractic: Chiropractic and Acupuncture services not covered. Facility: Skilled nursing/100 days per year no charge if authorized. Infertility treatment:: Testing paid at 50% of allowed charges. Home health care: Maximum of 100 days per calendar year.

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.