SAN FRANCISCO ELECTRICAL WORKERS RETIREE HEALTH & WELFARE PLAN
IBEW LOCAL 6
2010-2011 COMPREHENSIVE MEDICAL BENEFITS SUMMARY

COVERED FEATURES	COMPREHENSIVE MEDICAL INSURANCE SELF-FUNDED PPO Coverage Worldwide
CHOICE OF PROVIDERS	Choose any physician. Choose a PPO Physician/Hospital to receive maximum benefits.
PLAN MAXIMUMS	$750,000 per calendar year per family member. $2,000,000 lifetime maximum per family member. (Effective 2/1/11 no lifetime 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. **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.
HOSPITAL CONFINEMENT *Room and board, surgery, anesthesia and miscellaneous*	Pays 80% after deductible (60% out of network)
DOCTOR VISITS – Office/Hospital	Pays 80% after deductible (60% out of network)
OUTPATIENT LAB & X-RAYS	Pays 80% after deductible (60% out of network)
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.
PREVENTATIVE HEALTH CARE *(Routine checkups, well baby care, immunizations, pap smears, etc.).*	Pays 80% after deductible (60% out of network) for: Annual Physical- up to $300 maximum, Preventative care & immunizations. Pays 100% for: Pap Smear & pelvic exam, Mammography Screening (some age based limitations), Colonoscopy, Flexible sigmoidoscopy, Fecal occult blood test, Prostate Cancer Screening.
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.
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.
MATERNITY CARE Mother/Newborn Hospital Expenses Newborn Care	(**Members and Spouses only)** Same as hospital confinement coverage shown above, for 48 hours following normal vaginal delivery and 96 hours following delivery by caesarian section. Covered while mother is confined. Pays 80% after deductible (60% out of network).
EYE EXAMINATIONS/GLASSES	Covered through Vision Service Plan; $10 co-payment; examination and lenses available every 12 months; new frames available every 24 months.
MENTAL HEALTH/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)	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 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.
PHYSICAL THERAPY	Pays 80% after deductible (60% out of network). Services subject to medical review for determination of medical necessity and appropriate treatment frequency.
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.
PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT	Pays 80% after deductible (60% out of network). Durable rental of medical equipment, not to exceed the purchase price (Serious mental illnesses covered as any other condition)
EMERGENCY CARE AND OUT OF SERVICE AREA (*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
DENTAL COVERAGE	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.	Chiropractic & Acupuncture treatments covered as any other medical expense (based on allowable charges and limited to 30 visits per calendar year). These services are subject to medical review for determination of medical necessity and appropriate treatment frequency. Skilled nursing facility limited to $75 per day up to 100 days per confinement (reduced by days of hospital confinement). Blood donations for your own scheduled surgery covered if physician recommends. For those participants and dependents eligible for Medicare, the Plan will cover the difference between eligible expenses, as defined in the Plan, and amounts paid by Medicare in accordance with the above outline of benefits.