

I.B.E.W. LOCAL #332 HEALTH & WELFARE TRUST FUND
2009 ACTIVE PLAN BENEFITS SUMMARY CHART

MEDICAL

PLAN FEATURES	TRUST SELF-FUNDED MEDICAL PLAN		KAISER HMO Group #780	HEALTH NET HMO Group #57826	PACIFICARE HMO Group #140167
	In-Network	Out-of-Network			
Provider Network	Anthem Blue Cross PPO	Use Any Provider	Kaiser Permanente	Health Net	PacifiCare
Network Service Area	California		California	California	California
Who Provides Care	To receive the highest level of benefits, use an Anthem Blue Cross PPO network provider. <u>Note:</u> If you are referred to an out-of-network provider by an in-network provider, out-of-network benefits still apply.		Kaiser Permanente doctors and facilities only.	Coordinate care through a Health Net HMO network primary care physician.	Coordinate care through a PacifiCare HMO network primary care physician.
Calendar-Year Deductible	\$ 100 per person \$ 300 per family	\$ 100 per person \$ 300 per family	None	None	None
Calendar-Year Out-of-Pocket Maximum for Covered Expenses	\$2,500 per person \$5,000 per family	\$5,000 per person \$10,000 per family	\$1,500 per person \$3,000 per family	\$1,500 per person \$3,000 two persons \$4,500 per family	\$2,000 per person \$6,000 per family
Medical Plan Annual Maximum	\$2,000,000		Unlimited	Unlimited	Unlimited
Medical Plan Lifetime Maximum	\$2,000,000		Unlimited	Unlimited	Unlimited
Eligibility Age Limits for Dependent Children	Under age 19, or under age 25 if attending an accredited school on a full-time basis.		Same	Same	Same
Preauthorization Requirements	Your physician is responsible for obtaining any required preauthorization through Anthem Blue Cross.	You or your physician must contact Anthem Blue Cross at least seven days before: <ul style="list-style-type: none"> • Hospital admission • Use of outpatient facility • Certain diagnostic procedures • Outpatient surgery 	All authorizations must be coordinated through your Kaiser physician.	All authorizations must be coordinated through your Health Net primary care physician including specialists, x-rays and lab work.	All authorizations must be coordinated through your PacifiCare primary care physician including specialists, x-rays and lab work.

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Benefits for Most Covered Services	After calendar-year deductible, plan pays:		You pay a \$15 copay per visit. No benefits are payable at non-Kaiser facilities, except in case of emergency.	You pay a \$15 copay per visit. No benefits are payable outside the network, except in case of emergency.	You pay a \$15 copay per visit. No benefits are payable outside the network, except in case of emergency.
	80% of Anthem Blue Cross's negotiated rate except for inpatient Hospital charges. 90% of Anthem Blue Cross's negotiated rate for inpatient Hospital charges.	60% of usual, customary and reasonable charges.			
Preventative Care Benefits – Preventative Physical Exams	Plan pays 100% of eligible expenses for annual preventative physical exam in an Anthem Blue Cross network provider doctor's office (up to \$250 per person, per calendar year), then regular benefits apply. No deductible applies.	No benefit provided out-of-network.	Plan pays 100% after you pay \$15 copay. Annual routine physical examinations for employment, sports, college entrance, etc. not covered.	Plan pays 100% after you pay \$15 copay. Annual routine physical examinations for employment, sports, college entrance, etc. not covered.	Plan pays 100% after you pay \$15 copay. Annual routine physical examinations for employment, sports, college entrance, etc. not covered.
Well Baby Care (Infants through age 23 months)	80% of Anthem Blue Cross's negotiated rate up to 8 well baby visits. No deductible applies.	No benefit provided out-of-network.	Plan pays 100% after you pay \$15 copay.	Plan pays 100% after you pay \$15 copay.	Plan pays 100% after you pay \$15 copay.
Immunizations and Vaccinations	Plan pays 100% for children up to 36 months of age for physician-recommended immunizations and vaccinations.	No benefit provided out-of-network.	Plan pays 100%.	Plan pays 100%.	Plan pays 100% after you pay \$15 copay.
Infertility Treatment	No benefit provided.		Limited benefits. Contact Kaiser for specific coverage.	Limited benefits. Contact Health Net for specific coverage.	No benefit provided.
X-Ray / Laboratory / Imaging Services	Plan pays 100% Anthem Blue Cross PPO network provider services. Calendar-year deductible is waived.	Plan pays 60% of usual, customary and reasonable charges after calendar-year deductible is applied.	Plan pays 100%.	Plan pays 100%.	Plan pays 100%.

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Hospital Inpatient and Outpatient Facility Services	Plan pays 90% of Anthem Blue Cross's negotiated rate; calendar-year deductible is waived when admitted to an in-network hospital facility as an inpatient. See preauthorization requirements.	Plan pays 60% of usual, customary and reasonable charges after calendar-year deductible is applied.	Plan pays 100% after you pay \$100 copay per admission.	Plan pays 100% after you pay \$100 copay per admission.	Plan pays 100% after you pay \$100 copay per admission.
Emergency Room Services	After calendar-year deductible, plan pays:		Plan pays 100% after you pay \$100 copay per emergency room visit (waived if admitted).	Plan pays 100% after you pay \$100 copay per emergency room visit (waived if admitted).	Plan pays 100% after you pay \$100 copay per emergency room visit (waived if admitted).
	80% of Anthem Blue Cross's negotiated rate.	60% of usual, customary and reasonable charges.			
Urgent Care Center Services	After calendar-year deductible, plan pays:		Plan pays 100% after you pay \$15 copay.	Plan pays 100% after you pay \$50 copay.	Plan pays 100% after you pay \$50 copay.
	80% of Anthem Blue Cross's negotiated rate.	60% of usual, customary and reasonable charges.			
Ambulance	After calendar-year deductible, plan pays:		Plan pays 100%.	Plan pays 100%.	Plan pays 100%.
	80% of Anthem Blue Cross's negotiated rates.	60% of usual, customary and reasonable charges.			
Chiropractic Care	Regular in- and out-of-network benefits apply for up to 30 visits per calendar year limited to \$35 per visit.		You pay a \$15 copay per visit for up to 30 visits per calendar year.	You pay a \$15 copay per visit for up to 30 visits per calendar year.	You pay a \$15 copay per visit for up to 30 visits per calendar year.
Infertility Treatment	No benefit provided.		Limited benefits. Contact Kaiser for specific coverage.	Limited benefits. Contact Health Net for specific coverage.	No benefit provided.
Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy	After calendar-year deductible, plan pays:		You pay a \$15 copay per visit.	Plan pays 100%.	You pay a \$15 copay per visit.
	80% of Anthem Blue Cross's negotiated rates.	60% of usual, customary and reasonable charges.			

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Mental Health / Chemical Dependency	Except in emergencies, you must obtain preauthorization of mental health services by calling Anthem Blue Cross at 1-800-274-7767. Anthem Blue Cross works with a network of counseling and treatment providers throughout California. These include psychologists, psychiatrists, marriage and family counselors and social workers where needed, inpatient and outpatient hospitals, and facilities for mental health treatment.		<u>Mental Health</u> Outpatient benefits: Up to 20 visits per calendar year at \$15 copay per visit at Kaiser facility. Inpatient benefits: Psychiatric care up to 45 days per calendar year. \$100 copay per admission.	<u>Mental Health</u> Outpatient benefits: Non-severe: up to 20 visits per calendar year at \$30 copay per visit for mental health or chemical dependency through a Health Net network provider. Severe: unlimited visits at \$15. copay per visit through a Health Net network provider. Inpatient benefits: Non-severe: no charge. Severe: unlimited days, no charge. Chemical dependency: No charge up to 30 visits per year. Detox: \$100 copay per admission.	As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage. \$15 copay per visit. Detox: \$100 copay per admission. Additional Coverage: Supplemental coverage is provided by Beat It! for Chemical Dependency after PacifiCare benefits are exhausted.	
	After calendar-year deductible, plan pays:					
	Outpatient Counseling benefits: 80% of Anthem Blue Cross's negotiated rate up to 16 counseling sessions in a 12-month period.		60% of usual, customary and reasonable charges.	<u>Chemical Dependency</u> Detox: \$100 copay per admission. Outpatient services: \$15 copay per visit. Additional Coverage: Supplemental coverage is provided by Beat It! for Chemical Dependency after Kaiser benefits are exhausted.	Severe: unlimited visits at \$15. copay per visit through a Health Net network provider. Inpatient benefits: Non-severe: no charge. Severe: unlimited days, no charge. Chemical dependency: No charge up to 30 visits per year. Detox: \$100 copay per admission. Additional Coverage: Supplemental coverage is provided by Beat It! for Chemical Dependency after Health Net benefits are exhausted.	
	Psychiatric Hospital benefits: 80% of Anthem Blue Cross's negotiated rate up to a maximum of 45 days in a 12-month period.		If for emergency services, 50% of usual, customary and reasonable charges. Non-emergency, no benefit provided out-of-network.			
	Psychiatric Residential Care benefits: 80% of Anthem Blue Cross's negotiated rate limited to 270 days in a 12-month period.		No benefit provided out-of-network.			
BEAT IT! PROGRAM FOR ALCOHOL AND SUBSTANCE ABUSE						

	<p>Beat It! Is a specialty program for the treatment of alcohol and substance abuse. This program is available to all eligible participants and their dependents, including members who have chosen the Kaiser, Health Net or PacifiCare plan for medical coverage.</p> <p>The benefits include up to 28 days of inpatient treatment in a pre-approved facility or an outpatient counseling program with a pre-approved counselor. These benefits are paid at 100% for first-time use of the program, inpatient or outpatient. Second-time use of the program will be paid at 80%. Alcohol and substance abuse treatment benefits are subject to a lifetime maximum of \$25,000. All inpatient programs include 6 months to 1 year of aftercare and family involvement. Outpatient counseling with approved counselors includes 40 hours of one-on-one therapy sessions.</p>
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	In-Network	Out-of-Network			

<p>Prescription Drugs</p>	<p>Retail Drugs (up to 30-day supply) –</p> <p>Only at participating pharmacies</p> <ul style="list-style-type: none"> • Generic – You pay \$10 copay. • Preferred Brand – You pay 20%; \$15 minimum up to a \$25 maximum copay. • Non-Preferred Brand – You pay 30%; \$30 minimum up to a \$75 maximum copay. <p>Mail Order Drugs (up to 90-day supply) –</p> <p>Only through Postal Prescription Services (PPS)</p> <ul style="list-style-type: none"> • Generic – You pay \$20 copay. • Preferred Brand – You pay 20%; \$40 minimum up to a \$75 maximum copay. • Non-Preferred Brand – You pay 30%; \$75 minimum up to a \$150 maximum copay. <p>Some drugs require preauthorization.</p> <p>Medical plan deductible and coinsurance amounts do not apply to this benefit feature.</p>	<p>Limited out-of-network benefits provided.</p> <p>Contact the Plan's Pharmacy Benefit Manager, RESTAT, at: 1-800-248-1062.</p>	<p>Retail Drugs (up to 100-day supply) –</p> <p>Only at Kaiser pharmacy</p> <ul style="list-style-type: none"> • Generic – You pay \$10 copay. • Brand – You pay \$20 copay. <p>Mail Order Drugs refills only (up to 100-day supply) –</p> <p>Only through Kaiser</p> <ul style="list-style-type: none"> • Generic – You pay \$20 copay. • Brand – You pay \$40 copay. • Not all drugs are available through mail order. 	<p>Retail Drugs (up to 30-day supply) –</p> <ul style="list-style-type: none"> • Generic – You pay \$10 copay. • Brand – You pay \$20 copay. • Non-Formulary Brand & Generic Drugs – Not covered. <p>Mail Order Drugs (up to 90-day supply) –</p> <ul style="list-style-type: none"> • Generic – You pay \$20 copay. • Brand – You pay \$40 copay. • Non-Formulary Brand & Generic Drugs – Not covered. 	<p>Retail Drugs (up to 30-day supply) –</p> <ul style="list-style-type: none"> • Generic – You pay \$10 copay. • Brand – You pay \$20 copay. <p>Mail Order Drugs (up to 90-day supply) –</p> <ul style="list-style-type: none"> • Generic – You pay \$20 copay. • Brand – You pay \$40 copay. <p>All non-formulary drugs must be preauthorized by PacifiCare.</p>
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DENTAL

PLAN FEATURES	TRUST SELF-FUNDED DENTAL PLAN	
	In-Network	Out-of-Network
Provider Network	Interplan / DentiNex® Dental PPO – a network of participating dentists, specialists and orthodontists who have agreed to charge lower fees for their services.	Use Any Provider
Network Service Area	California	
Who Provides Care	You can select any dentist of your choice. To receive the Plan's highest level of benefits and pay the lowest out-of-pocket costs, use a DentiNex® Dental PPO network dentist.	
Calendar-Year Deductible	\$25 per person for Class III – Major Services.	
Calendar-Year Maximum Benefit	\$2,000 per person.	
Benefits for Most Covered Services	Plan pays a percentage of eligible expenses: <ul style="list-style-type: none"> • 100% for Preventive services (Class I) (exams, cleanings, x-rays) • 80% for Basic services (Class II) (fillings, root canals, extractions) • 60% for Major services (Class III) (crowns, bridges, dentures) after calendar-year deductible of \$25. 	
	In-network eligible expenses are based upon the Interplan / DentiNex® Dental PPO negotiated rates.	Out-of-network eligible expenses are based upon the maximum Plan allowance for usual, customary and reasonable charges.
Orthodontia	Plan pays 60% of eligible expenses after calendar-year deductible of \$25. Plan Lifetime Maximum benefit: \$2,000 per person.	
Predetermination of Benefits	If charges for a course of treatment will exceed \$500, it is recommended that your dentist submit a treatment plan to United Administrative Services (Plan Administrator) for review ahead of time. The dentist and you will receive an estimate of the Plan's benefits, which you should review together.	

VISION

For more information, go to Vision Service Plan's (VSP's) website at vsp.com.

PLAN FEATURES	FREQUENCY ⁽¹⁾	COPAY	VSP Network Provider	Out-of-Network
Eye Exam	12 months	None	Covered	Covered up to \$45.
Lenses ⁽²⁾	24 months	\$25 for lenses and frames.	Covered Single vision, lined bifocal, lined trifocal lenses. Polycarbonate lenses for dependent children.	Covered up to \$45 / single vision Covered up to \$65 / Bifocal Covered up to \$85 / Trifocal Covered up to \$125 / Lenticular
Frame	24 months Once every 12 months for children age 14 and under.		\$120 retail frame allowance plus 20% off of any out-of- pocket costs.	Covered up to \$47
Contact Lenses ⁽³⁾ • Medically Necessary ⁽⁴⁾ • Elective	12 months 12 months	None None	Covered. Covered up to \$105. ⁽⁵⁾	Covered up to \$210. Covered up to \$105.
Laser Vision Correction ⁽⁶⁾	N/A	N/A	Discounted services	None

(1) Based on your last date of service.

(2) Your plan provides a 20 percent discount on non-covered complete pairs of prescription glasses when provided by a VSP doctor.

(3) Patients choosing contacts use their eligibility for a frame and lenses.

(4) Medically necessary contact lenses must be prescribed for certain conditions which prevent you from wearing eyeglasses and must be pre-approved by VSP.

(5) Your plan also includes a 15 percent discount off the cost of your contact lens exam (fitting & evaluation) when you receive contact lens services from a VSP doctor.

(6) Discounted laser vision correction surgery (PRK and LASIK) is available through VSP contracted laser centers. Program availability may vary based on location and regulatory approval.

SHORT-TERM DISABILITY

Short-term Disability (STD) coverage pays a benefit for employees only if you cannot work due to a non-occupational accident or sickness. Benefit begins on the first day for an accident or hospital confinement and on the eighth day for non-hospital illness. Dependents and those making self-payments under COBRA are not eligible for Short-Term Disability benefits.

PLAN FEATURES	WEEKLY BENEFIT	MAXIMUM BENEFIT
Short-Term Disability Benefit	First Thirteen (13) Weeks: \$100 Second Thirteen (13) Weeks: \$150	\$1,300 \$1,950

EMPLOYEE LIFE INSURANCE

Life insurance benefits are available to employees only. Dependents and those making self-payments under COBRA are not eligible for Life Insurance benefits. Life insurance is provided through a contract with Principal Life Insurance Company.

PLAN FEATURES			
Summary of Life Insurance Benefit	The Plan provides \$22,000 of Group Term Life Insurance (24-hour coverage).		
Reductions in Life Insurance Amount Due to Age	Your Life Insurance amount will be reduced based on your age, as shown below:		
	Attained Age	Reduction %	Benefit Amount
	65 through 69	50%	\$11,000
	70 through 74	75%	\$5,500
	75 through 79	85%	\$3,300
	80 through 84	90%	\$2,200
85 or over	95%	\$1,100	

An additional \$28,000 of Group Term Life Insurance is provided for members who have 5 or more years of vested service credit under the I.B.E.W. Local #332 Pension Plan – Part A.

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Accidental Death and Dismemberment insurance benefits are available to employees only. Dependents and those making self-payments under COBRA are not eligible for Accidental Death and Dismemberment insurance benefits. Accidental Death and Dismemberment insurance is provided through a contract with Principal Life Insurance Company.

PLAN FEATURES	AMOUNT	
Loss Type	Life	\$22,000
	One hand, one foot, or sight of one eye	\$11,000
	Two or more of the above losses	\$22,000

CONTACT INFORMATION FOR BENEFIT QUESTIONS

Member / Customer Service Phone, Email	TRUST SELF-FUNDED MEDICAL PLAN	KAISER HMO Group #780	HEALTH NET HMO Group #57826	PACIFICARE HMO Group #140167
	<p>United Administrative Services (Plan Administrator) (408) 288-4400 1-800-541-8059 www.uastpa.com</p> <p>Anthem Blue Cross Preferred Provider Organization (PPO) (Refer to Group #170017) (408) 288-4400 1-800-541-8059 www.anthem.com/ca</p>	<p>1-800-464-4000</p> <p>www.kaiserpermanente.org</p>	<p>1-800-522-0088</p> <p>www.healthnet.com</p>	<p>1-800-624-8822</p> <p>www.pacificare.com</p>

VISION SERVICE PLAN
<p>1-800-877-7195</p> <p>www.vsp.com</p>

BEAT IT! (Alcohol and Substance Abuse)
<p>1-800-828-3939</p> <p>www.beatiteap.com</p>

INTERPLAN HEALTH GROUP'S DENTINEX® DENTAL PPO
<p>1-800-444-4036, ext. #7129</p> <p>www.interplanhealth.com</p>

RESTAT Rx (Pharmacy Benefit Manager)
<p>1-800-248-1062</p> <p>www.restat.com</p>

POSTAL PRESCRIPTION SERVICES (Mail Order Rx)
<p>1-800-552-6694</p> <p>www.ppsrx.com</p>

This summary has been designed to give you a general overview of the Plan's provider benefits effective January 1, 2009. It does not, however, attempt to explain all the details, provisions, limitations, restrictions and exclusions of the Plan's benefits. The Board of Trustees reserves the right to change or terminate the plans or specific provisions of the Plan at any time. For additional information about the Plan's benefits, please contact the Plan Administrator, United Administrative Services: (408) 288-4400 or toll-free, 1-800-541-8059.