IBEW LOCAL 595 HEALTH & WELFARE PLAN
ACTIVE EMPLOYEES and NON-MEDICARE RETIREES
COMPARISON OF BENEFITS SUMMARY Effective 2/1/2021

COVERAGE FEATURES	Self Funded INDEMNITY PLAN Coverage Worldwide *	Self Funded ADDITIONAL DEDUCTILE INDEMNITY PLAN Without Vision or Dental Coverage Worldwide	KAISER PERMANENTE HMO	UNITED HEALTHCARE HMO *
CHOICE OF PROVIDERS	Choose an Anthem Blue Cross physician and save money. Choose an Anthem Blue Cross hospital to receive maximum benefits. $250 charge will apply for not using an Anthem Blue Cross hospital when available.	Choose an Anthem Blue Cross physician and save money. Choose an Anthem Blue Cross hospital to receive maximum benefits. $250 charge will apply for not using an Anthem Blue Cross hospital when available.	Must use Kaiser Permanente Facilities and Providers.	Must use United Healthcare/PacifiCare HMO providers.
PLAN MAXIMUMS	**No annual or lifetime plan maximums for Covered Charges that are considered "essential health benefits" under Patient Protection Affordable Care Act.**	**No annual or lifetime plan maximums for Covered Charges that are considered "essential health benefits" under Patient Protection Affordable Care Act.**	No plan maximum.	No plan maximum.
OUT-OF-POCKET MAXIMUMS	For in-network Anthem Blue Cross providers: All benefits paid at 80% after satisfying deductible of $200 per person, maximum $400 per family. For non-network: All benefits paid at 60% of reasonable and customary charges after satisfying deductible of $200 per person, maximum $400 per family. All covered benefits paid at 100% after $10,000 of covered expenses after deductible.	For in-network Anthem Blue Cross providers: All benefits paid at 80% after satisfying deductible of $3554per person, maximum $3754 per family. For non-network: All benefits paid at 60% of reasonable and customary charges after satisfying deductible of $3554 per person, maximum $3774 per family. All covered benefits paid at 100% after $10,000 of covered expenses after deductible.	$1,500 Individual $3,000 Family	$2,000 Individual $6,000 Family
HOSPITAL CONFINEMENT Room and Board, surgery, anesthesia and miscellaneous	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible. There is a $250 charge will apply for not using an Anthem Blue Cross hospital when available.	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible. There is a $250 charge will apply for not using an Anthem Blue Cross hospital when available.	No charge.	No charge.
DOCTOR VISITS Office Hospital	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible.	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible.	$10 per visit No charge.	$20 per visit
OUTPATIENT LAB & X-RAYS	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible.	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible.	No charge.	No charge.

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COVERAGE FEATURES	Self Funded INDEMNITY PLAN Coverage Worldwide *	Self Funded ADDITIONAL DEDUCTILE INDEMNITY PLAN Without Vision or Dental Coverage Worldwide	KAISER PERMANENTE HMO	UNITED HEALTHCARE HMO *
PRESCRIPTION DRUGS	**Benefits through OptumRx:** (30-day supply) $5 co-pay – Generic $20 co-pay – Preferred Brand $35 co-pay Non-Preferred Brand $4000 (Individual)/$8000 (Family) Maximum Out-of-Pocket/calendar year Mail Order available (90-day Supply)	**Benefits through OptumRx;** (30-day supply) $5 co-pay – Generic $20 co-pay – Preferred Brand $35 co-pay Non-Preferred Brand $1046 (Individual)/$3754 (Family) Maximum Out-of-Pocket/calendar year Mail Order available (90-day Supply)	**Benefits through Kaiser:** $10 per prescription / refill at Kaiser Permanente Pharmacies (up to a 100 day supply) – Generic $25 per prescription / refill at Kaiser Permanente Pharmacies (up to a 100 day supply) - Brand	**Benefits through OptumRx (formerly Prescription Solutions):** (30-day supply) $10 co-pay – Generic/Brand $20 co-pay – Non-Formulary Mail Order available (90-day Supply)
MATERNITY CARE Mother's Hospital Expenses Mother's Office Expenses **Newborn Care:** must be enrolled within 31 days from date of birth.	(Members and Spouses only) Paid as any other hospital confinement For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible	(Members and Spouses only) Paid as any other hospital confinement For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible	No Charge. *$5 per visit pre-natal care* No charge in hospital if enrolled within 31 days of birth	No Charge. No charge in hospital if enrolled within 31 days of birth
PHYSICAL THERAPY	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible	$10 per visit (short term)	$20 per visit (short term)
CHIROPRACTIC & ACUPUNCTURE	Covered as any other medical expense (based on allowable charges and Plan guidelines).	Covered as any other medical expense (based on allowable charges and Plan guidelines).	Chiropractic - $10 per visit; 30 visits per calendar year. Acupuncture – Not covered	Not covered
PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT	Durable medical equipment - rental or purchase as allowed by Plan. For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible	Durable medical equipment - rental or purchase as allowed by Plan. For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible	No charge when medically necessary and prescribed by Plan physician and in accordance with DME formulary guidelines.	No charge with authorization. $5,000 annual maximum per calendar year.
AMBULANCE SERVICES	Pays 80% after deductible if required to move patient from place of injury or illness to nearest hospital equipped to provide necessary care.	Pays 80% after deductible 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 if authorized and medically necessary.

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EMERGENCY CARE AND OUT OF AREA SERVICE *(Outside of Plan facilities)*	Coverage applies worldwide.	Coverage applies worldwide.	$75 co-pay *(waived if admitted).* Worldwide coverage for Urgent & Emergency services. Follow-up and routine care not covered.	$50 copay, waived if admitted. Routine care not covered.
SPECIAL NOTES	Non-network Indemnity payments are based on allowable charges (reasonable and customary). Blood donations for your own surgery covered if physician recommends.	Non-network Indemnity payments are based on allowable charges (reasonable and customary). Blood donations for your own surgery covered if physician recommends.	*Allergy testing $10 per visit.* *Allergy injection $3 per visit.*	Infertility Not Covered
MENTAL HEALTH* Outpatient Inpatient *Unlimited for AB88 conditions	**Covered as any other medical expense (based on allowable charges and Plan guidelines).**	**Covered as any other medical expense (based on allowable charges and Plan guidelines).**	**Outpatient: $10 per individual visit $5 per group visit** **Inpatient – No Charge**	**Covered as any other medical expense (based on allowable charges and Plan guidelines).**
CHEMICAL DEPENDENCY ***(Alcohol or Drug Abuse)***	**Covered as any other medical expense (based on allowable charges and Plan guidelines).**	**Covered as any other medical expense (based on allowable charges and Plan guidelines).**	**Inpatient detoxification – no charge** **Outpatient: $10 per individual visit $5 per group visit.**	**Covered as any other medical expense (based on allowable charges and Plan guidelines).**
MEMBER ASSISTANCE PROGRAM	Benefits are provided by Optum Health. Please see separate booklet for services provided			
DENTAL COVERAGE	Benefits provided by Delta Dental or UHC Dental. Please see separate booklets for services provided.	**No dental benefits available under this option.**	Benefits provided by Delta Dental or UHC Dental. Please see separate booklets for services provided.	Benefits provided by Delta Dental or UHC Dental. Please see separate booklets for services provided.
VISION COVERAGE	Benefits are provided by Vision Service Plan (VSP). Please see separate booklet for services provided.	**No vision benefits available under this option.**	Benefits are provided by Vision Service Plan (VSP). Please see separate booklet for services provided.	Benefits are provided by Vision Service Plan (VSP). Please see separate booklet for services provided.

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"Year" means calendar year unless otherwise indicated.

NOTE: This "COMPARISON OF BENEFITS SUMMARY" 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.