LOCAL UNION 831

Employer Health Fund

MEDICAL PLAN
COMPARISON BENEFITS CHART

Levels 1, 2, 3, and 4

January 1, 2020

NOTE: This is a comparison of benefits only. Consult the SPD or call the Trust Fund Office for further information concerning benefits.

Southern California Local Union 831 Employer Health Fund

Benefit Highlights…

Physicians Assistants Benefit

Effective June 1, 2006, the Southern California Local 831 - Employer Health Plan will cover Physician Assistants while performing medically necessary services within the scope of their license.

Hearing Aid Benefit

Effective November 1, 2000, Hearing Aids are covered under all 4 levels. Below is the Schedule of Benefits set forth by the Trustees:

Audiologist visit (hearing test)	up to $75.00 per visit
Ear Molds	up to $50.00 per mold
Hearing Aid	up to $800.00 per ear

These benefits are not subject to Plan Deductibles or co-insurance requirements.

The audiologist visit (hearing test) is limited to one per year. Ear molds and hearing aids are limited to one every four years for each ear except that ear molds are allowed up to twice a year, if needed, for each ear for an eligible child up to age 19 (eligible children over age 19 are subject to the four year limit).

If you are a Kaiser member, you must have your hearing examination performed at a Kaiser facility. You may then purchase your hearing aids from any dispenser and submit your bill to the Trust Office for reimbursement.

Contraceptive Devices Benefit

Effective January 1, 2006, the Plan's prescription coverage was extended to include most prescription contraceptive devices.

These include prescription oral, transdermal, injectable, and intravaginal contraceptive medications and contraceptive emergency kits (available only at retail).

Not included are over the counter contraceptives and prescription barrier contraceptives.

Except as noted above, prescriptions may be purchased at the retail pharmacy or through the mail order pharmacy.

Eligibility Requirements

The monthly work hours required to be eligible for Health Plan benefits under all Plan Levels is outlined below for the contribution rate of $10.70.

Schedule of Hours

	Level 1	Level 2	Level 3	Level 4
Hours needed @ $10.70	140	120	100	80
Benefit Credits Required	$1,498.00	$1,284.00	$1,070.00	$856.00
Maximum "Bank"	$7,490.00	$6,420.00	$5,350.00	$4,280.00

You may accumulate up to a maximum of five (5) months of Benefit Credits/Hours in your Benefit Credit/Hour Bank. As you know, if you work more hours than are necessary to earn the Benefit Credits/Hours required for the level of coverage you have selected, you will accumulate reserve Benefit Credits/Hours in the Benefit Credit/Hour Bank. These Benefit Credits/Hours will be used if you don't otherwise have enough work hours to maintain eligibility, until there are insufficient Credits to use for a month's eligibility.

Indemnity Dental Plan (Plan Levels 1, 2 and 3)

Effective October 1, 2006, the Southern California Local 831 - Employer Health Plan will cover dental implants to replace teeth that were extracted while you were covered by the Plan.

The Plan will cover sealants for first and second molars for eligible children up to age 15. This benefit, however, is limited to once every three years.

Southern California Local Union 831 Employer Health Fund

Benefit Highlights…

Indemnity Plan Prescription Drug Benefit

Effective September 1, 2009, the Trust Fund is pleased to offer Optum Rx. All retail prescriptions must be purchased at Optum Rx Network Pharmacies. Most major pharmacies are on the Plan.

Prescription Drug Mail Order member co-payment is 10% per prescription through Optum Rx. Please note that all maintenance drugs must be supplied through the Mail Order Program.

Prescriptions will be paid as described below.

Plan pays: 80% of Allowable Charges-Retail (if purchased at the pharmacy) - subject to no deductible

Plan pays: 90% of Allowable Charges-Mail Order - subject to no deductible

Selecting Your Plan Level

To ensure your eligibility for Health coverage, select a Plan Level with the monthly hour requirements that best matches your work hours.

To request an enrollment form or to receive further assistance in selecting a Plan Level, contact the Trust Fund Office at 1.877.572.7005.

Health – Buy-Up Option

Effective January 1, 2010, the Health Buy-up Option is available to **those members who qualify** and is **limited to a six (6) consecutive month period.**

Buy-up Option qualifications:

If an eligible employee's work hours drop so that he or she would lose eligibility due to insufficient hours or you do not have enough bank hours, then you will be allowed to purchase up to 50% of your required hours to continue your eligibility. You must pay the highest Health & Welfare contribution rate stated in the collective bargaining agreement in effect at the time of your credit hour purchase.

Participant must have at least 50% of the hours required for the Level Option they are under to qualify for the Buy-Up Option.

Level 1	140 hours - must have 70 hours
Level 2	120 hours - must have 60 hours
Level 3	100 hours - must have 50 hours
Level 4	80 hours - must have 40 hours

For Example purposes only:

An employee is covered under Plan Level 3 but his hours worked dropped to 50, The required number of hours for Plan Level 3 is 100 hours a month. The employee has no bank hours. The difference between the hours worked and hours required is 50 hours. You would multiply 50 hours @ $10.70 = $535.00

Required hours for Level 3 - 100 hours
Hours actually worked 50 hours
Difference 50 hours

50 hours x $10.70 = $535.00 Buy-Up

Questions?

Should you have any questions, please contact Trust Fund Office at 1.877.572.7005.

Sincerely,

BOARD OF TRUSTEES

Southern California Local Union 831 Employer Health Fund

Benefit Highlights...

EMPLOYEE ASSISTANCE PROGRAM: CLAREMONT EAP

The Trust now offers an employee assistance program (EAP) designed to assist eligible members with mental health and substance use disorder issues, in addition to the benefits we offer for treatment of mental health and substance use disorder issues specified elsewhere in this Plan. It has contracted with Claremont EAP to coordinate the delivery of these types of services, as well as offer assistance with other issues including, but not limited to, family and financial counseling, basic legal matters, and child and elder care services.

Please call **Claremont EAP's toll-free number 1.800.834.3773** to access these services and to get a referral to a provider who is appropriate for your needs. For more information about this program, please call the Trust fund Office at 1.877.572.7005.

Chemical Dependency Case Management Services

Claremont will provide chemical dependency case management services according to Plan allowances. Claremont services include connecting members to an appropriate facility, case management for up to 12 months and general support related to alcohol and drug abuse. Extended eligibility for substance abuse counseling and treatment is available only to the Employee, and is available up to six (6) months after loss of Plan eligibility. As of January 1, 2015, Employees who were covered under the Kaiser plan and qualify for extended eligibility will receive benefits for substance abuse counseling and treatment services managed through Claremont under the indemnity plan, at the same coverage Level that applied to the Kaiser coverage and subject to the $300-per-calendar year individual deductible.

In addition, Claremont EAP provides other services for you and your eligible dependents.
For more information please refer to Section 9 of the Summary Plan Description

QUESTIONS? CALL:

Local 831 Trust Fund Office . . . . . (multi-lingual) 1.877.572.7005
www.localunion831trustfunds.com 1.626.279.3080

Kaiser - www.kp.org . . . . . (multi-lingual) 1.800.464.4000
(Spanish) 1.800.788.0616

Anthem Blue Cross of California - www.anthem.com 1.800.274.7767

Optum Rx - www.optumrx.com 1.800.797.9791

Employee Assistance Program: Claremont EAP 1.800.834.3773
www.claremonteap.com/pages/ca.html and use company name: Local 831

This Comparison Chart presents general information intended to help you enroll in the plans offered by the Southern California Local 831 - Employer Health Fund. Not all Plan provisions, limitations and exclusions are included in this brochure. In the event of any conflict between the information contained in this brochure and the Plan provisions, the Explanations of Coverage in the Summary Plan Description will govern. Copies of these documents are available in the Southern California Local 831 - Employer Health Fund's Administrative Office during normal business hours.

Local Union 831 – *Employer Health Fund* – Level 1

	Indemnity Plan	Kaiser-Permanente HMO
Life Insurance	$25,000 Employee Only ($5,000 AD & D)	Same
* **Medical**		No Deductible
Deductible	$300/Calendar year/Individual $600/Calendar year/Family	No Deductible No Deductible
Percentage Payable	80% of Usual, Customary and Reasonable Charges for non-PPO providers; 90% of contracted amount if PPO utilized	No Charges In Hospital $25 co-pay per Doctor Visit / $75.00 Emergency $40 co-pay per most physician specialist visits
Child Immunizations	100% of UCR / No deductible 100% of PPO Rate / No deductible up to 18 years old	No Charge for immunizations for children or adults
Hospital Daily Rate Room and Board	90% if PPO Hospital and Pre-admission review procedures are followed 80% if non-PPO Hospital and Pre-admission review procedures are followed. There will be a 10% reduction in benefit if Utilization Review not used for Inpatient Benefits. All services are subject to Medical Necessity.	No Charge (includes maternity) Out-patient; $25 co-pay per visit
Non-Contracted Outpatient Surgical Facility Rates	Los Angeles/Orange/San Diego: Maximum allowable $2,900.00 payable at 80%; Riverside/San Bernardino: Maximum allowable $2,450.00 payable at 80% San Luis Obispo/Santa Barbara/Kern: Maximum allowable $1,910.00 payable at 80% Ventura: Maximum allowable $2,340.00 payable at 80%	
Chiropractic, Physical Therapy, & Acupuncture	80% of UCR 90% of contracted amount if PPO utilized 18 Visits per Year for any combination of these services Subject to Review	No charge for Inpatient Physical Therapy Out-patient Physical Therapy; $25 co-pay **Chiropractic covered through Indemnity Plan 18 visits per year, subject to no deductible.** Acupuncture not covered
Durable Medical Equipment	80% of UCR; 90% of contracted amount if PPO utilized. Purchases in excess of $500.00 must be pre-authorized. All rental equipment must be pre-authorized.	Durable Medical Equipment covered through indemnity Plan subject to no deductible.
Skilled Nursing Facility/ Convalescent Hospital Daily Rate and Home Health Care	90% of contracted rate if PPO utilized. If you use non-PPO facilities/providers, benefits are payable at 50% of the contracted daily rate of the PPO facility nearest to the non-PPO facility where the services are rendered, with a limit of 60 days per calendar year. Maximum of 60 Days/combined benefit. Pre-authorization required.	Up to 100 days at no charge for skilled nursing care No Charge X-Ray and Lab Tests
Out-patient Mental Health Psychotherapy/Psychometric Testing	80% of UCR; 90% of contracted amount if PPO utilized	$25 co-pay/per Individual visit $12 co-pay per group visits
Diabetes Instruction	80% of UCR; 90% of contracted amount if PPO utilized. Maximum of one diabetes instruction per year.	$25 co-pay/Visit
Supplemental Accident Benefit	$300/Accident	N/A
Individual Out-of-Pocket Maximum	$4,900 in a calendar year	Unlimited
Inpatient Mental & Nervous Alcohol & Drug Abuse Out-patient Alcohol & Drug Rehabilitation	80% of UCR; 90% of contracted amount if PPO utilized 80% of UCR; 90% of contracted amount if PPO utilized 80% of UCR; 90% of contracted amount if PPO utilized	No charge In Medical Office; Individual $25 co-pay / Group therapy $5 co-pay / In Hospital; No Charge Transitional Residential; Recovery Services $0 per admission
Prescription Drug	Optum Rx, No Deductible Retail - 80% of Allowable Charges Mail Order - 90% of Allowable Charges	No Deductible. Filled at Kaiser pharmacies only No maximum up to a 30 day supp. per Rx $15 generic/$30 Brand
Dental	As with all PPO providers, Dental PPO Providers are subject to contracted rates	**Provided through Indemnity Plan**
Employee Deductible	No Deductible	
Dependent Deductible	$25/Calendar Year/Each Dependent	
% Payable	80% UCR or 80% of contracted allowance	
Calendar Year Maximum	$2,000/Covered Individual over age 19	
Orthodontia	Maximum of $3,500 per lifetime; does not apply to medically necessary orthodontia (Available for eligible children up to age 26 only)	**Provided through Indemnity Plan**
Vision	As with all PPO providers, Vision PPO Providers are subject to contracted rates	
	No Deductible	
	Eye Refraction = $ 90.00*	Eye Refraction Exam only/$25 co-pay
One (1) Pair of Lenses each 12 Consecutive Month Period	Single Vision Lenses = $ 112.50*	Eye Refraction Exam only for contact lenses
	Bi-focal Lenses = $150.00*	$60/provided through Indemnity Plan
	Tri-focal Lenses = $180.00*	**Materials Provided through Indemnity Plan**
	Progressive Lenses = $180.00*	
	Lentricular Lenses = $180.00*	PPO Providers are subject to contracted rates
	Contact Lenses/Each = $150.00*	
* Dollar limits only apply if over age 19.	Polycarbonate Lenses/Pair = $ 75.00*	
* Frequency only applies if over age 19.	(If required by Employer) Benefit for participants only	
	Frames (once every 24 months) = $ 150.00*	
	(See Conditions in Plan)	
Annual Physical Routine physical exams, mammograms, pap smears, prostate special antigen (psa) tests, all routine lab work, bone density screening (if no diagnosis, signs or symptoms), routine colonoscopies and adult immunizations.	100% of contracted allowance or 80% of UCR for non-contracted providers No Deductible	No charge

Local Union 831 – *Employer Health Fund* – Level 2

	Indemnity Plan	Kaiser-Permanente HMO
Life Insurance	$25,000 Employee Only ($5,000 AD & D)	Same
Medical		
Deductible	$300/Calendar year/Individual $600/Calendar year/Family	No Deductible No Deductible
Percentage Payable	80% of Usual, Customary and Reasonable Charges for non-PPO providers; 90% of contracted amount if PPO utilized	No Charges In Hospital $25 co-pay per Doctor Visit / $75.00 Emergency $40 co-pay per most physician specialist visits
Child Immunizations	100% of UCR / No deductible 100% of PPO Rate / No deductible up to 18 years old	No Charge for immunizations for children or adults
Hospital Daily Rate Room and Board	90% if PPO Hospital and Pre-admission review procedures are followed 80% if non-PPO Hospital and Pre-admission review procedures are followed. There will be a 10% reduction in benefit if Utilization Review not used for Inpatient Benefits. All services are subject to Medical Necessity.	No Charge (includes maternity) Out-patient; $25 co-pay per visit
Non-Contracted Outpatient Surgical Facility Rates	Los Angeles/Orange/San Diego: Maximum allowable $2,900.00 payable at 80%; Riverside/San Bernardino: Maximum allowable $2,450.00 payable at 80% San Luis Obispo/Santa Barbara/Kern: Maximum allowable $1,910.00 payable at 80% Ventura: Maximum allowable $2,340.00 payable at 80%	
Chiropractic, Physical Therapy, & Acupuncture	80% of UCR 90% of contracted amount if PPO utilized 18 Visits per Year for any combination of these services Subject to Review	No charge for Inpatient Physical Therapy Out-patient Physical Therapy; $25 co-pay **Chiropractic covered through Indemnity Plan 18 visits per year, subject to no deductible.** Acupuncture not covered
Durable Medical Equipment	80% of UCR; 90% of contracted amount if PPO utilized. Purchases in excess of $500.00 must be pre-authorized. All rental equipment must be pre-authorized.	Durable Medical Equipment covered through indemnity Plan subject to no deductible.
Skilled Nursing Facility/ Convalescent Hospital Daily Rate and Home Health Care	90% of contracted rate if PPO utilized. If you use non-PPO facilities/providers, benefits are payable at 50% of the contracted daily rate of the PPO facility nearest to the non-PPO facility where the services are rendered, with a limit of 60 days per calendar year. Maximum of 60 Days/combined benefit. Pre-authorization required.	Up to 100 days at no charge for skilled nursing care No Charge X-Ray and Lab Tests
Out-patient Mental Health Psychotherapy/Psychometric Testing	80% of UCR; 90% of contracted amount if PPO utilized	$25 co-pay/per Individual visit $12 co-pay per group visits
Diabetes Instruction	80% of UCR; 90% of contracted amount if PPO utilized. Maximum of one diabetes instruction per year.	$25 co-pay/Visit
Supplemental Accident Benefit	$300/Accident	N/A
Individual Out-of-Pocket Maximum	$4,900 in a calendar year	Unlimited
Inpatient Mental & Nervous Alcohol & Drug Abuse Out-patient Alcohol & Drug Rehabilitation	80% of UCR; 90% of contracted amount if PPO utilized 80% of UCR; 90% of contracted amount if PPO utilized 80% of UCR; 90% of contracted amount if PPO utilized	No charge In Medical Office; Individual $25 co-pay / Group therapy $5 co-pay / In Hospital; No Charge Transitional Residential; Recovery Services $0 per admission
Prescription Drug	Optum Rx, No Deductible Retail - 80% of Allowable Charges Mail Order - 90% of Allowable Charges	No Deductible. Filled at Kaiser pharmacies only No maximum up to a 30 day supp. per Rx $15 generic/$30 Brand
Dental	As with all PPO providers, Dental PPO Providers are subject to contracted rates	**Provided through Indemnity Plan**
Deductible per Person	$25/Calendar Year	
% Payable	70% UCR or 70% of contracted allowance	
Calendar Year Maximum	$1,500/Covered Individual over age 19	
Orthodontia	Maximum of $3,500 per lifetime; does not apply to medically necessary orthodontia (Available for eligible children up to age 26 only)	**Provided through Indemnity Plan**
Vision	As with all PPO providers, Vision PPO Providers are subject to contracted rates	
	No Deductible	
	Eye Refraction = $ 90.00*	Eye Refraction Exam only/$25 co-pay
One (1) Pair of Lenses each 12 Consecutive Month Period	Single Vision Lenses = $ 112.50* Bi-focal Lenses = $150.00* Tri-focal Lenses = $180.00* Progressive Lenses = $180.00* Lentricular Lenses = $180.00* Contact Lenses/Each = $150.00* Polycarbonate Lenses/Pair = $ 75.00*	Eye Refraction Exam only for contact lenses $60/provided through Indemnity Plan **Materials Provided through Indemnity Plan** PPO Providers are subject to contracted rates
* Dollar limits only apply if over age 19. * Frequency only applies if over age 19.	(If required by Employer) Benefit for participants only **Frames (once every 24 months)** = $ 150.00* (See Conditions in Plan)	
Annual Physical Routine physical exams, mammograms, pap smears, prostate special antigen (psa) tests, all routine lab work, bone density screening (if no diagnosis, signs or symptoms), routine colonoscopies and adult immunizations.	100% of contracted allowance or 80% of UCR for non-contracted providers No Deductible	No charge

Local Union 831 – *Employer Health Fund* – Level 3

	Indemnity Plan	Kaiser-Permanente HMO
Life Insurance	$25,000 Employee Only ($5,000 AD & D)	Same
Medical		
Deductible	$300/Calendar year/Individual $600/Calendar year/Family	No Deductible No Deductible
Percentage Payable	80% of Usual, Customary and Reasonable Charges for non-PPO providers; 90% of contracted amount if PPO utilized	No Charges In Hospital $25 co-pay per Doctor Visit / $75.00 Emergency $40 co-pay per most physician specialist visits
Child Immunizations	100% of UCR / No deductible 100% of PPO Rate / No deductible up to 18 years old	No Charge for immunizations for children or adult
Hospital Daily Rate Room and Board	90% if PPO Hospital and Pre-admission review procedures are followed 80% if non-PPO Hospital and Pre-admission review procedures are followed. There will be a 10% reduction in benefit if Utilization Review not used for Inpatient Benefits. All services are subject to Medical Necessity.	No Charge (includes maternity) Out-patient; $25 co-pay per visit
Non-Contracted Outpatient Surgical Facility Rates	Los Angeles/Orange/San Diego: Maximum allowable $2,900.00 payable at 80%; Riverside/San Bernardino: Maximum allowable $2,450.00 payable at 80% San Luis Obispo/Santa Barbara/Kern: Maximum allowable $1,910.00 payable at 80% Ventura: Maximum allowable $2,340.00 payable at 80%	
Chiropractic, Physical Therapy, & Acupuncture	80% of UCR 90% of contracted amount if PPO utilized 18 Visits per Year for any combination of these services Subject to Review	No charge for Inpatient Physical Therapy Out-patient Physical Therapy; $25 co-pay **Chiropractic covered through Indemnity Plan 18 visits per year, subject to no deductible.** Acupuncture not covered
Durable Medical Equipment	80% of UCR; 90% of contracted amount if PPO utilized. Purchases in excess of $500.00 must be pre-authorized. All rental equipment must be pre-authorized.	Durable Medical Equipment covered through indemnity Plan subject to no deductible.
Skilled Nursing Facility/ Convalescent Hospital Daily Rate and Home Health Care	90% of contracted rate if PPO utilized. If you use non-PPO facilities/providers, benefits are payable at 50% of the contracted daily rate of the PPO facility nearest to the non-PPO facility where the services are rendered, with a limit of 60 days per calendar year. Maximum of 60 Days/combined benefit. Pre-authorization required.	Up to 100 days at no charge for skilled nursing care No Charge X-Ray and Lab Tests
Out-patient Mental Health Psychotherapy/Psychometric Testing	80% of UCR; 90% of contracted amount if PPO utilized	$25 co-pay/per Individual visit $12 co-pay per group visits
Diabetes Instruction Supplemental Accident Benefit	80% of UCR; 90% of contracted amount if PPO utilized. Maximum of one diabetes instruction per year. $300/Accident	$25 co-pay/Visit N/A
Individual Out-of-Pocket Maximum	$4,900 in a calendar year	Unlimited
Inpatient Mental & Nervous Alcohol & Drug Abuse Out-patient Alcohol & Drug Rehabilitation	80% of UCR; 90% of contracted amount if PPO utilized 80% of UCR; 90% of contracted amount if PPO utilized 80% of UCR; 90% of contracted amount if PPO utilized	No charge In Medical Office; Individual $25 co-pay / Group therapy $5 co-pay / In Hospital; No Charge Transitional Residential; Recovery Services $0 per admission
Prescription Drug	Optum Rx, No Deductible Retail - 80% of Allowable Charges Mail Order - 90% of Allowable Charges	No Deductible. Filled at Kaiser pharmacies only No maximum up to a 30 day supp. per Rx $15 generic/$30 Brand
Dental	As with all PPO providers, Dental PPO Providers are subject to contracted rates	**Provided through Indemnity Plan**
Deductible per Person	$25/Covered Individual/Calendar Year	
% Payable	60% of UCR or 60% of contracted allowance	
Calendar Year Maximum	$1,200.00/Covered Individual over age 19	
Orthodontia	Maximum of $3,500 per lifetime; does not apply to medically necessary orthodontia (Available for eligible children up to age 26 only)	**Provided through Indemnity Plan**
Vision	Not Covered	Eye Refraction Exam only/$25 Co-pay
Annual Physical Routine physical exams, mammograms, pap smears, prostate special antigen (psa) tests, all routine lab work, bone density screening (if no diagnosis, signs or symptoms), routine colonoscopies and adult immunizations.	100% of contracted allowance or 80% of UCR for non-contracted providers No Deductible	No charge

Local Union 831 – *Employer Health Fund* – Level 4

	Indemnity Plan	Kaiser-Permanente HMO
Life Insurance	$25,000 Employee Only ($5,000 AD & D)	Same
Medical		
Deductible	$300/Calendar year/Individual $600/Calendar year/Family	No Deductible No Deductible
Percentage Payable	80% of contracted amount if PPO utilized 60% of UCR if Non-PPO	$25 co-pay per Doctor Visit / $75.00 Emergency $40 co-pay per most physician specialist visits
Hospital Daily Rate Room and Board	80% of UCR if PPO Hospital and Pre-admission review procedures are followed (See Summary Plan Description for other Limitations). 60% if non-PPO Hospital and pre-admission review procedures are followed. There will be a 10% reduction in benefit if Utilization Review not used for Inpatient Benefits. All services are subject to Medical Necessity.	No Charge (includes maternity)
Non-Contracted Outpatient Surgical Facility Rates	Los Angeles/Orange/San Diego: Maximum allowable $2,900.00 payable at 60%; Riverside/San Bernardino: Maximum allowable $2,450.00 payable at 60% San Luis Obispo/Santa Barbara/Kern: Maximum allowable $1,910.00 payable at 60% Ventura: Maximum allowable $2,340.00 payable at 60%	
Chiropractic, Physical Therapy, & Acupuncture	60% of UCR 80% of contracted amount if PPO utilized 18 Visits per Year for any combination of these services Subject to Review	Out-patient Physical Therapy; $25 co-pay **Chiropractic covered through Indemnity Plan 18 visits per year, subject to no deductible.** Acupuncture not covered
Durable Medical Equipment	60% of Usual, Customary and Reasonable charges; 80% of contracted amount if PPO utilized. Purchases in excess of $500.00 must be pre-authorized. All rental equipment must be pre-authorized.	Durable Medical Equipment covered through indemnity Plan subject to no deductible.
Skilled Nursing Facility/ Convalescent Hospital Daily Rate and Home Health Care	80% of contracted rate if PPO utilized. If you use non-PPO facilities/providers, benefits are payable at 50% of the contracted daily rate of the PPO facility nearest to the non-PPO facility where the services are rendered, with a limit of 60 days per calendar year. Maximum of 60 Days/combined benefit. Pre-authorization required.	Up to 100 days at no charge for skilled nursing care No Charge X-Ray and Lab Tests
Out-patient Mental Health Psychotherapy/Psychometric Testing	60% of UCR; 80% of contracted amount if PPO utilized	$25 co-pay/per Individual & Group visit $12 co-pay
Diabetes Instruction	60% of UCR; 80% of contracted amount if PPO utilized. Maximum of one diabetes instruction per year.	$25 co-payment
Individual Out-of-Pocket Maximum	$4,900 in a calendar year. Applies to PPO providers only. If non-PPO providers are used no individual out-of-pocket maximum will apply.	Unlimited
Inpatient Mental & Nervous Alcohol & Drug Abuse Out-patient Alcohol & Drug Rehabilitation	60% of UCR; 80% of contracted amount if PPO utilized 60% of UCR; 80% of contracted amount if PPO utilized 60% of UCR; 80% of contracted amount if PPO utilized	No charge In Medical Office; Individual $25 co-pay / Group therapy $5 co-pay / In Hospital; No Charge Transitional Residential; Recovery Services $0 per admission
Prescription Drug (Out-patient)	Not Covered	Not Covered
Dental	Not Covered	Not Covered
Vision	Not Covered	Eye Refraction Exam only/$25 co-pay
Annual Physical	Not Covered	Scheduled Well-Baby Visit - No charge Scheduled Maternity Visit - No charge Physicals - No charge

***** If non-PPO providers are used, no individual out-of-pocket maximum will apply.