GOLD COAST JOINT BENEFITS TRUST
COMPARISON OF MEDICAL PLAN OPTIONS FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

THE FOLLOWING CHART CONTAINS A SUMMARY OF BENEFITS PROVIDED BY THE TRUST-SPONSORED HMO PLAN AND BY THE TRUST'S INDEMNITY MEDICAL PLAN. FOR BENEFITS PROVIDED UNDER THE HMO PLAN, THE CHART SHOWS THE PARTICIPANT'S REQUIRED COPAY FOR EACH TYPE OF SERVICE. BENEFITS ARE EXPLAINED IN GREATER DETAIL IN THE HMO EVIDENCE OF COVERAGE AND IN THE INDEMNITY MEDICAL PLAN DESCRIPTION BOOKLET. SHOULD THERE BE A DISCREPANCY BETWEEN THIS DOCUMENT AND THE APPLICABLE EVIDENCE OF COVERAGE OR PLAN DESCRIPTION BOOKLET, THE TERMS, CONDITIONS, AND EXCLUSIONS OF THE APPLICABLE EVIDENCE OF COVERAGE OR PLAN DESCRIPTION BOOKLET WILL PREVAIL.

	YOUR PLAN OPTIONS – Benefits in effect as of July 1, 2019	
	KAISER PERMANENTE[(1)]	**GOLD COAST TRUST INDEMNITY MEDICAL PLAN IV**
Type of Plan	Health Maintenance Organization	Indemnity Plan (PPO Plan) To access names of network providers via the internet: - Participants living inside the state of California – Access the Anthem Blue Cross PPO Network at www.anthem.com/ca - Participants living outside the state of California – Access the PHCS PPO Network at www.multiplan.com You may also call the Administrative Office, Delta Health Systems, at (800) 556-5918 for assistance.
Choice of Physicians	Kaiser Permanente Medical Centers located in Southern California and Buenaventura Medical Group.	Choice of network or non-network physicians. Network physician services are paid at a higher benefit level than those services rendered by a non-network physician. See Deductibles/Coinsurance.
Dependent Coverage	Lawful spouse or domestic partner and eligible children to age 26.	Lawful spouse or domestic partner and eligible children to age 26.
Claims	No need to submit claim forms.	Claim forms required except when network providers are used. No claim forms required for chiropractic benefits or prescription drugs.
Deductibles/Copayments/ Coinsurance	Certain copayments required as noted below.	$400 deductible per individual per calendar year, maximum of $1,200 per family. After the deductible has been met, the Plan will pay 90% for all covered medical charges rendered by a network hospital or provider (physicians and laboratories), except as otherwise noted, until the calendar year out-of-pocket maximum has been reached. The Plan will pay 50% of usual & customary charges for all covered medical charges rendered by a non-network hospital or provider (physicians and laboratories), except as otherwise noted. The deductible is waived for preventive care, hospice services, chiropractic care, and prescription drugs when a network provider/pharmacy is used.

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Annual Out-of-Pocket (OOP) Maximum **Medical Expenses** **Prescription Drug Expenses**	The annual out-of-pocket limit on all covered medical and prescription drug expenses paid by Kaiser is $1,500 per individual; $3,000 per family. Premium or non-covered services are not included in the out-of-pocket maximum.	The **medical** calendar year out-of-pocket (OOP) maximum for covered medical charges is $2,000 per individual; $4,000 per family. Once the OOP maximum has been reached, the Plan will pay 100% of covered expenses for the remainder of the calendar year. The OOP maximum applies to network provider charges only. The calendar year deductible applies to the out-of-pocket maximum. Non-network provider charges, premiums, and penalties for failure to obtain pre-authorization for services do not apply to the OOP maximum. The **prescription drug** calendar year OOP maximum for covered prescription drug charges is $4,600 per individual; $9,200 per family. The OOP applies to prescription drugs obtained at an Express Scripts network pharmacy, or through the Express Scripts mail-order program only. Non-network pharmacy charges, premiums, and penalties for failure to comply with preferred drug step therapy and utilization management programs do not apply to the OOP maximum.
Benefit Maximum **Calendar Year** **Lifetime**	 None None	 None None
BENEFITS		
Physician **Office** **Hospital** **Surgery**	 $30 copayment per visit No charge for inpatient physician visits No charge	 90% in-network; 50% non-network **NOTE: The Plan complies with Physician Emergency Room services payable at 90% of network rates and 90% of non-network usual and customary charges, but not less than what is required by law.**
Hospital Inpatient Services	$250 copayment required per Hospital admission. No further charge thereafter for covered services for that admission.	90% in-network; 50% non-network. Preauthorization must be obtained prior to hospital admission (except in emergencies) or benefits will be paid at 80% of usual plan benefits.
Outpatient Surgical Centers (Ambulatory Surgical Centers)	$30 copayment per procedure for Outpatient Surgery	90% in-network when services are performed at a free-standing outpatient surgical center. **Not covered when using a non-network facility.** Preauthorization must be obtained prior to hospital admission (except in emergencies) or benefits will be paid at 80% of usual plan benefits. **Note: Surgical services for cataract, arthroscopic and colonoscopy procedures must be performed at an in network free-standing outpatient surgical Center that is NOT affiliated with a hospital outpatient surgical unit.**
Emergency Room	$50 copayment per visit in or out of area. Copayment waived if admitted.	90% in-network; 90% of usual & customary charges at a non-network facility, but not less than required by law.
Urgent Care Center	$30 copayment per visit at Urgent Care Center.	90% in-network; 50% non-network.

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Ambulance	$50 per trip.	90% in-network; 90% non-network. Air ambulance and other modes of transport considered based on medical necessity.
Skilled Nursing Facility	No charge. Up to 100 days per benefit period.	90% in-network; 50% non-network. Plan pays up to 90 days per calendar year if the confinement begins within 14 days of a hospital stay of 3 or more days.
Maternity **Physician** **Hospital**	No charge for prenatal and first postpartum visit. $250 copayment per admission, no charge thereafter.	Covered on the same basis as any other illness.
X-Ray and Lab	No charge[2]	90% in-network; 50% non-network.
Routine Immunizations	No charge[2]	Covered under Preventive Services.
Allergy Testing	$30 copayment per visit.	90% in-network; 50% non-network.
Allergy Serum	No charge[2]	
Periodic Health Evaluations, Well-Woman Visit, Well Baby Care, and Preventive Services	$30 copayment per visit. No charge for Well Baby visits (23 months or younger). **This Plan is in compliance with Health Care Reform to provide recommended preventive care services at no charge.**	The Plan will cover 100% of covered charges for Preventive Care Services when those services are provided by an in-network provider. Preventive care services provided by a non-network provider are not covered. It is the intent of this Plan to comply with the provisions of Health Care Reform; therefore, the list of covered services may be subject to change. Refer to the government website https://www.healthcare.gov/coverage/preventive-care-benefits/ for the most current list of preventive care services that health plans are required to cover pursuant to Health Care Reform.
Home Health Care	No charge. Up to 2 hours per visit, maximum 3 visits per day, 100 visits per calendar year.	90% in-network; 80% non-network. Plan pays up to 60 visits per calendar year.
Hospice Care	No charge. Benefits are in lieu of any other benefits payable by this Plan.	100% in-network, deductible waived. 90% non-network, after deductible. The Plan will pay Hospice Care for home or inpatient care for up to 6 months. Following 6 months, medical necessity must be re-certified no less frequently than every 30 days, up to a lifetime maximum of 12 months.
EAP Program	Up to 5 in-person counseling visits for each personal situation. Available through Anthem EAP at no charge. Call 1-800-999-7222 to obtain authorization and find a provider. Any additional services/treatment needed must be obtained through the Kaiser Health Plan.	Up to 5 in-person counseling visits for each personal situation. Available through Anthem EAP at no charge. Call 1-800-999-7222 to obtain authorization and find a provider. Find articles, browse resources, or take an online class at anthemeap.com. Topics include finding child and elder care, handling grief and loss, and managing stress.

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Mental Health and Substance Abuse	Mental/Behavioral Health: $30/individual visit. $15/group visit. No charge for other outpatient services. Mental/Behavioral Health Inpatient: $250/admission. Substance Abuse: $30/individual visit. $5/group visit. $5/day for other outpatient services. Substance Abuse Inpatient – limited to detoxification only: $250/admission. Transitional Recovery Services: $100/admission.	90% in-network; 50% non-network. All mental health and substance abuse benefits are paid on the same basis as other medical benefits, subject to the calendar year deductible. Access the Anthem Blue Cross PPO Network at www.anthem.com/ca. To obtain authorization for inpatient services, providers should call 1-800-274-7767.
Durable Medical Equipment	No charge	90% in-network; 80% non-network. DME expenses in excess of $2,000 must be preauthorized by Anthem Blue Cross.
Podiatry	$30 copayment per visit with physician referral.	90% in-network; 50% non-network.
Nutritional Counseling	Nutritional Health Education counseling provided at $30 copayment per individual visit; no charge for group class. Online information is also available.	90% in-network; 50% non-network. 15 visits maximum per lifetime. Applies to Nutritional Counseling for Diabetes.
Chiropractic Care	$10 copayment per visit, up to 30 visits per calendar year. $50 allowance for appliances per calendar year.	$20 copayment per visit, up to 30 visits per calendar year. Benefits available **ONLY** through Chiropractic Health Plan of California (CHPC) Network Providers. Call (800) 995-2442 to access this program.
Prescription Drugs Obtained Through a Retail Pharmacy	Copayment per prescription or refill; up to a 30-day supply; subject to formulary: Non-Specialty Drugs: Generic - $15 Brand Name - $30 Specialty Drugs: 50% copayment up to a maximum of $200 per script. 50% copayment for sexual dysfunction prescriptions.	Copayment per prescription or refill; up to a 30-day supply: Generic - $15 Brand Formulary – The greater of $30 or 20% Brand Non-Formulary – The greater of $50 or 35% Preferred Drug Step Therapy and Utilization Management Programs are in effect. Prescriptions must be obtained at retail pharmacies contracting with Express Scripts. Maintenance medication must be obtained through the Mail Order Program – see next section.

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Prescription Drugs Obtained Through the Mail-Order Program	Copayment per prescription or refill; up to a 100-day supply; subject to formulary: <u>Non-Specialty Drugs:</u> Generic - $30 Brand Name - $60	Maintenance medication must be obtained through the Mail Order Program. After the second fill of a maintenance medication at a retail pharmacy, future refills for that prescription will only be filled through the Mail Order Program. You may get up to a 90-day supply through Mail Order. Generic - $30 Brand Formulary - $60 Brand Non-Formulary – $100 Preferred Drug Step Therapy and Utilization Management Programs are in effect. Prescriptions must be obtained through the Express Scripts Mail-Order program.

(1) If you elect Kaiser, you must reside or work within the Kaiser service area. Please call Member Services at (800) 464-4000 to determine if you live/work within Kaiser's service area.

(2) There is no charge for x-rays, lab tests, immunizations, and allergy testing; however, if these services are provided in conjunction with a doctor's office visit, the doctor's office visit copayment will apply.