

SAN FRANCISCO ELECTRICAL WORKERS
HEALTH & WELFARE TRUST
720 MARKET STREET, SUITE 700 • SAN FRANCISCO, CA 94102
(415) 263-3670 • FAX (415) 263-3672

2008-2009 OPEN ENROLLMENT NOTICE

June 2008

TO: SAN FRANCISCO ELECTRICAL WORKERS ACTIVE/EARLY RETIREE PLAN PARTICIPANTS

FROM: BOARD OF TRUSTEES

RE: OPEN ENROLLMENT- Plan selection for 8/1/2008 – 7/31/2009

The Open Enrollment is being held during the month of July for coverage effective August 1, 2008. **Depending on where you reside**, you may choose from the following medical plans:

- ♦ INDEMNITY PLAN
- ♦ KAISER
- ♦ BLUE SHIELD (Replacing PacifiCare Effective 8/1/08)

A comparison of the more significant benefits offered by these Plans is enclosed for your information. You are urged to study this comparison carefully and select the Plan you feel best meets the needs of your family. **Note that only under special circumstances, will participants be allowed to change plans outside the open enrollment period. This is why it is important for you to review all of the information before you make a change.** You may also contact the Fund Office if you would like additional information regarding the Plans.

If you wish to remain under your present coverage, no action is required.

If you are changing coverage, complete the enclosed Request Form and return it to the Plan Office immediately. ALL CHANGE APPLICATIONS MUST BE RECEIVED NO LATER THAN July 25, 2008.

If you are currently enrolled in PacifiCare your coverage will automatically be transitioned to Blue Shield unless you elect Kaiser or the Indemnity Plan.

Blue Shield is making every effort to ensure that each Participant's current Primary Care Physician selections are automatically transferred to Blue Shield and has provided a special toll free number, (800) 303-5921, to respond to questions concerning benefits or transition issues. This number is available between Monday and Friday, 8 AM – 5 PM PST.

Forms are also enclosed for your convenience if there has been a change in dependent status or you wish to change your beneficiary designation.

If you have any questions concerning this information or require additional information, do not hesitate to contact the Plan Office at (415) 263-3670.

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE TRUST
720 Market Street, Suite 700, San Francisco, CA 94102
(415) 263-3670

PLAN CHANGE REQUEST FORM

I have read the enclosed Comparison of Benefits and would like to change to the following Plan. (Please check the appropriate box, fill in the information requested below and return this form and the information, along with the appropriate enrollment form and/or identification card, will be sent to you.) If you are currently enrolled in PacifiCare and do not select the Indemnity Plan or Kaiser, you will automatically be enrolled in the Blue Shield HMO effective 08/01/08.

- INDEMNITY PLAN (AVAILABLE WORLD WIDE)
- KAISER (CALIFORNIA ONLY- must reside within a 30 mile radius of a Kaiser facility)
- BLUE SHIELD (Limited to certain geographic areas in California Only- contact Plan Office for more information or the Blue Shield website @ www.blueshieldca.com).

If you have had a change in dependent status or wish to change your beneficiary designation, please check the appropriate box.

- CHANGE IN BENEFICIARY STATUS
- CHANGE IN DEPENDENT STATUS

Your Name (please print)

Signature

Social Security Number

Street Address

City, State, Zip Code

**SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN
IBEW LOCAL 6**

2008-2009 COMPARISON OF BENEFITS SUMMARY

COVERED FEATURES	COMPREHENSIVE MEDICAL COVERAGE	HEALTH MAINTENANCE ORGANIZATIONS	
	INDEMNITY PLAN Coverage Worldwide	KAISER PERMANENTE	BLUE SHIELD
CHOICE OF PROVIDERS	Choose any physician or hospital. Reduced charges available from PPO hospital and physician networks.	Must use Kaiser Permanente facilities and providers.	Must use Health Plan Providers.
PLAN MAXIMUMS	\$750,000 per calendar year per family member. \$2,000,000 plan max. per family member.	No plan maximum.	No plan maximum.
OUT-OF-POCKET MAXIMUMS	All benefits paid at 80% after satisfying deductible of \$50 per person, maximum of \$100 family. All covered benefits paid at 100% after \$5,000 of covered expenses.	\$1,500 Individual \$3,000 Family	\$2,000 individual \$4,000 two-party \$6,000 family
HOSPITAL CONFINEMENT Room and Board, surgery, anesthesia and miscellaneous	Pays 80% after deductible	No charge	No charge
DOCTOR VISITS Office Hospital	Pays 80% after deductible Pays 80% after deductible	\$15 per visit No charge	\$20 per visit No charge
OUTPATIENT LAB & X-RAYS	Pays 80% after deductible	No charge.	No charge
PREVENTATIVE HEALTH CARE <i>(Routine check-ups, well baby care, immunizations, pap smears, etc.)</i>	Pays 80% after deductible for: Annual Physical- up to \$300 maximum Immunization Inoculations Preventative care and immunizations Pays 100% for: Mammograms, Pap Smears & Pelvic Exams, Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy, Prostate Cancer Screening	\$15 per visit \$5 Well Baby preventive care visits (0-23 Months)	No Charge No charge for well baby.
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.	No charge if authorized and medically necessary	No charge.
MATERNITY CARE Mother's Hospital Expenses Mother's Expenses - Office Newborn Care	<u>(Members & Spouses/Domestic Partners only)</u> Same as hospital confinement shown above for 48 hours following vaginal delivery and 96 hours following deliver by caesarian section. Pays 80% after deductible. Covered while mother is confined	No charge \$5 Prenatal Care & First Post Partum Visit No charge in hospital. Newborns must be enrolled within 31 days of birth.	No charge No charge No charge in hospital if enrolled within 31 days of birth
EYE EXAMINATIONS EYE GLASSES	Covered by Vision Service Plan. \$10 co-payment; Examination and lenses provided every 12 months; new frames available every 24 months.	\$15 per visit (Exams Only) through Kaiser Covered by Vision Service Plan. \$10 co-payment; Examination and lenses provided every 12 months; \$200 new frame allowance available every 24 months.	Covered by Vision Service Plan. \$10 co-payment; Examination and lenses provided every 12 months; \$200 new frame allowance available every 24 months.

COVERED FEATURES	COMPREHENSIVE MEDICAL COVERAGE	HEALTH MAINTENANCE ORGANIZATIONS	
	INDEMNITY PLAN	KAISER PERMANENTE	BLUE SHIELD
MENTAL HEALTH Outpatient Inpatient	[Coverage through PacifiCare Behavioral Health (PBH). All services must be pre-authorized by PBH: eligible participants are required to utilize network facilities and providers for mental health and substance abuse treatment] \$0 Co-pay; 30 visit limit Severe mental illness-\$0 Co-pay; unlimited visits; Same as hospital confinement shown above.	\$15 up to 20 visits per calendar year. (No limits for Mental Health Parity diagnosis) \$7 per Group Visits up to 20 per year Up to 45 days per benefit period (No limits for Mental Health Parity diagnosis)	[Coverage through PacifiCare Behavioral Health (PBH). All services must be pre-authorized by PBH: eligible participants are required to utilize network facilities and providers for mental health and substance abuse treatment] \$0 Co-pay; 30 visit limit Severe mental illness-\$0 Co-pay; unlimited visits; 100% coverage up to 30 days per calendar year after any applicable admission fee.
CHEMICAL DEPENDENCY <i>(Alcohol and Drug dependency)</i>	All benefits, including detox, provided through the PacifiCare Behavioral Health Substance Abuse Program. \$25,000 Annual Maximum; \$35,000 Lifetime Maximum \$0 Co-pay; covered at 100%	\$15 per Visit. - Outpatient visit through Chemical Dependency Recovery Program at Kaiser of Behavioral Medicine Department. \$5 Group Visits. \$100 Transitional Residential services (up to 60 days per calendar year, not to exceed 120 days in any five year period. \$0 Hospitalization covered for Detox from Kaiser. <u>Alternatively, benefits are provided through the PacifiCare Behavioral Health Substance Abuse Program (See description under Indemnity Plan).</u>	All benefits provided through the PacifiCare Behavioral Health Substance Abuse Program. \$25,000 Annual Maximum; \$35,000 Lifetime Maximum \$0 Co-pay outpatient; 100% covered patient <u>Blue Shield covers medical acute detoxification the same as medical – no charge for inpatient hospitalization.</u>
PHYSICAL THERAPY	Pays 80% after deductible. Claims subject to peer review for medical necessity and determination of appropriate treatment.	\$15 Co-pay (short term)	Short-term therapy \$20 copay.
MEMBER ASSISTANCE PROGRAM (MAP) <i>(Available to all household members)</i>	(Coverage through PacifiCare Behavioral Health) 3 visits/\$0 co-pay: Resource Referrals – Childcare, Eldercare, Legal, Financial, Emotional Issues, Work Issues, Addiction Treatment	(Coverage through PacifiCare Behavioral Health) 3 visits/\$0 co-pay: Resource Referrals – Childcare, Eldercare, Legal, Financial, Emotional Issues, Work Issues, Addiction Treatment	(Coverage through PacifiCare Behavioral Health) 3 visits/\$0 co-pay: Resource Referrals – Childcare, Eldercare, Legal, Financial, Emotional Issues, Work Issues, Addiction Treatment
PRESCRIPTION DRUGS	Administered through RxAmerica. Individual responsible for 20% co-payment payable to pharmacy at time prescription is filled. Note: Substantial savings may be obtained through the use of mail order prescription service.	\$10 generic/\$20 brand named per prescription or refill at Kaiser Permanente Pharmacies up to a 100-day supply.	\$15 (generic)/\$30 (brand named) per prescription or refill for a 30-day supply. \$30 (generic) /\$60 (brand named) for a 90-day supply of mail order prescriptions. Home Self-injectable 20% up to \$100 co-pay maximum per prescription
PROSTHETIC DEVICES & DURABLE MEDICAL EQUIPMENT	Pays 80% after deductible. Rental of medical equipment, not to exceed the purchase price.	No charge.	Prosthetics & Orthotics equipment and devices no charge. Durable Medical Equip. no charge. \$5,000 maximum per calendar year.
EMERGENCY CARE AND OUT OF AREA SERVICE <i>(Outside of Plan facilities)</i>	Coverage applies worldwide. Charges for certain emergency related treatment is covered under the \$5,000 in full in-patient Hospital benefit described above	\$25 Co-pay. Worldwide coverage for urgent or emergency services. Follow-up and routine care covered at Kaiser facility. Waived if admitted directly to hospital.	\$50 copay, waived if admitted. Routine care not covered.
DENTAL COVERAGE	Covered by Delta Dental.	Covered by Delta Dental.	Covered by Delta Dental
SPECIAL NOTES Your eligible dependents are: Lawful Spouse Registered Domestic Partner Unmarried children through age 18 Unmarried children ages 19 through 24 if full-time students	Chiropractic & Acupuncture treatments covered as any other medical expense, subject to medical review for medical necessity and appropriate treatment frequency. Indemnity payments are based on allowable charges. Blood donations for your own surgery covered if physician recommends.	Chiropractic covered at \$15 per visit, limited to 30 visits per benefit year. Acupuncture services are not covered. \$15 per Visit Allergy and/or Testing \$3 Allergy Injection Visits	Chiropractic and Acupuncture services not covered. \$20 per visit for allergy testing, allergy serum is included. Home health care maximum of 100 visits per calendar year. Infertility treatment testing paid at 50% of allowed charges.

“Year” means Calendar year unless otherwise indicated.

NOTE: This comparison of benefit coverage 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.