

SAN FRANCISCO ELECTRICAL WORKERS
HEALTH & WELFARE TRUST
720 MARKET STREET, SUITE 700 • SAN FRANCISCO, CA 94102
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2008-2009 OPEN ENROLLMENT NOTICE

June 2008

TO: SAN FRANCISCO ELECTRICAL WORKERS 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 or KAISER SENIOR ADVANTAGE**
- ◆ **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.

If you are currently enrolled in Secure Horizon you will be automatically transferred to the Indemnity Plan unless you elect Kaiser Senior Advantage. Blue Shield does not have a plan for Medicare eligible retirees. However, by selecting the self-funded Indemnity Plan program, retirees will have the opportunity to continue to be treated by their current providers.

Continued on Other Side

REMINDER: All Members who are eligible for Medicare must sign up for both Parts A (Hospital) and B (other medical) of Medicare. If you are in the indemnity plan, your claims will be processed as though you are covered by Medicare, even if you fail to sign up. Medicare eligible retirees or dependents who elect Kaiser but do not enroll in Kaiser Senior Advantage will be charged the difference between the premium for the Senior Advantage and the amount charged to the Trust.

Medicare-eligible Retirees are reminded not to enroll in a separate Medicare Part D prescription program outside of the plan. The prescription drug benefit you currently receive under the Plan (whether Indemnity Plan or Kaiser Senior Advantage) provides better coverage, at less cost to you, than other Medicare Part D programs. As long as you are eligible to have prescription drug coverage through the Plan, you are considered to have “Creditable Coverage”; therefore, if at some later date you choose to enroll in Medicare Part D outside this plan, you will not be charged a late penalty for delayed enrollment.

Please note that while the Plan advises you NOT to enroll in Medicare Part D outside the plan, you must still enroll for both Medicare Part A and Part B to be eligible for full coverage.

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.)

Non-Medicare Retirees

- 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).

Medicare Retirees

- INDEMNITY PLAN (AVAILABLE WORLD WIDE)
- KAISER SENIOR ADVANTAGE (CALIFORNIA ONLY - must reside within a 30 mile radius of a Kaiser facility)

Your Name (please print)

Signature

Social Security Number

Street Address

City, State, Zip Code

[Attached is a schedule showing the monthly co-payment rates for January 1, through December 31, 2008.]

Retiree Co-Payment Schedule (January 1- December 31, 2008)

Early Retirees (Age 55-62)	
Plan	Monthly Payment
Kaiser	1,169.00
Blue Shield (HMO)	1,259.00
Indemnity Plan	1,566.00

Early Retirees (Age 62-64) who will reach Full Retiree Membership status at age 65*	
Plan	Monthly Payment
Kaiser-Single	468.00
Kaiser-Family	701.00
Blue Shield-Single (HMO)	504.00
Blue Shield-Family (HMO)	756.00
Indemnity Plan-Single	626.00
Indemnity Plan-Family	940.00

*Full Retiree Status at age 65: Under age 59 at the time hourbank runs out following retirement.

Regular Retirees (Age 62-64) [Full Status Membership at age 62**]	
Plan	Monthly Payment
Kaiser	300.00
Indemnity Plan	300.00

**Full Retiree Status at age 62: Age 59 or older at the time hourbank runs out following retirement.

Disabled Retirees (under age 65)/ & Surviving Spouses for all Plans***	
Age	Monthly Payment
Under Age 65	250.00
Over Age 65 retirees who attained, or will attain, age 75 on or after 1/1/2007	100.00
Retirees who attained Age 75 before 1/1/2007	0.00

***Blue Shield's HMO is not available to Medicare Eligible Retirees/Surviving Spouses.

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

2008-2009 COMPREHENSIVE MEDICAL BENEFITS SUMMARY

COVERED FEATURES	COMPREHENSIVE MEDICAL INSURANCE
	INDEMNITY PLAN Coverage Worldwide
CHOICE OF PROVIDERS	Choose any physician. Choose a PPO Physician/Hospital to receive maximum benefits.
PLAN MAXIMUMS	\$750,000 per calendar year (per family member) \$2,000,000 plan maximum (per family member)
OUT OF POCKET MAXIMUMS	All benefits paid at 80% after \$50 per person (Medicare)/\$100 per person (non-Medicare), maximum \$100 per family (Medicare)/\$200 family (non-Medicare). All covered benefits paid at 100% after \$5,000, of incurred covered expenses in a calendar year.
HOSPITAL CONFINEMENT <i>Room and board, surgery, anesthesia and miscellaneous</i>	Pays 80% after deductible
DOCTOR VISITS Office Hospital	Pays 80% after deductible Pays 80% after deductible
OUTPATIENT LAB & X-RAYS	Pays 80% after deductible
PREVENTATIVE HEALTH CARE <i>(Routine checkups, well baby care, immunizations, pap smears, etc.).</i>	Pays 80% after deductible for: Annual Physical- up to \$300 maximum, Preventative & immunizations for children to 16, Immunization inoculations. Pays 100% for: Pap Smear & pelvic exam, Mammography Screening (some age based limitations), Colonoscopy, Flexible sigmoidoscopy, Fecal occult blood test, Prostate Cancer Screening.
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.
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.
MATERNITY CARE Mother/Newborn Hospital Expenses Mother's Expenses Newborn Care	(Members and Spouses only) Same as hospital confinement coverage shown above, for 48 hours following normal vaginal delivery and 96 hours following delivery by caesarian section. Covered while mother is confined. Pays 80% after deductible.
EYE EXAMINATIONS/GLASSES	Covered through Vision Service Plan; \$10 co-payment; examination and lenses available every 12 months; new frames available every 24 months.
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.
CHEMICAL DEPENDENCY <i>(Alcohol or drug abuse)</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%
PHYSICAL THERAPY	Pays 80% after deductible. Services subject to medical review for determination of medical necessity and appropriate treatment frequency.
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.
PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT	Pays 80% after deductible. Durable rental of medical equipment, not to exceed the purchase price (Serious mental illnesses covered as any other condition)
EMERGENCY CARE AND OUT OF SERVICE AREA <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
DENTAL COVERAGE	Covered by Delta Dental.
SPECIAL NOTES Your eligible dependents are: Lawful Spouse Unmarried children through age 18 Unmarried children ages 19 through 24 if full time students.	Chiropractic & Acupuncture treatments covered as any other medical expense (based on allowable charges and Plan guidelines). These services are subject to medical review for determination of medical necessity and appropriate treatment frequency. Skilled nursing facility limited to \$75 per day up to 100 days per confinement (reduced by days of hospital confinement). Blood donations for your own scheduled surgery covered if physician recommends. For those participants and dependents eligible for Medicare, the Plan will cover the difference between eligible expenses, as defined in the Plan, and amounts paid by Medicare in accordance with the above outline of benefits.

SAN FRANCISCO ELECTRICAL WORKERS RETIREE HEALTH & WELFARE PLAN
IBEW LOCAL 6
2008-2009 HEALTH MAINTENANCE ORGANIZATIONS COMPARISON OF BENEFITS SUMMARY

COVERAGE FEATURES	KAISER NON-MEDICARE	KAISER PERMANENTE SENIOR ADVANTAGE (Medicare HMO Plan)	BLUE SHIELD NON MEDICARE
CHOICE OF PROVIDERS	Must use Kaiser facilities and providers	Must use Kaiser facilities and providers	Must use Health Plan provider
PLAN MAXIMUMS	No plan maximum	No plan maximum	No plan maximums.
OUT OF POCKET MAXIMUMS	\$1,500 individual \$3,000 family	\$1,500 individual \$3,000 family	\$2,000 individual \$4,000 two-party \$6,000 family
HOSPITAL CONFINEMENT <i>Room and board, surgery, anesthesia and miscellaneous</i>	No charge	No charge	No charge
DOCTOR VISITS Office Hospital	\$15 per visit No charge	\$15 per visit No charge	\$20 per visit No charge
OUTPATIENT LAB & X-RAYS	No charge	No charge	No charge
PREVENTATIVE HEALTH CARE <i>(Routine checkups, well baby care, immunizations, pap smears, etc.).</i>	\$15 per visit \$5 Well Baby preventive care visits (0-23 months)	\$15 per visit	\$20 per visits No charge for well baby.
AMBULANCE SERVICES	No charge if authorized and medically necessary.	No charge if authorized and medically necessary.	No charge
MATERNITY CARE Mother's Hospital Expenses Mother's Expenses Newborn Care	No Charge No charge Inpatient Care \$5 Prenatal Care & First postpartum office visit No charge in hospital. Newborns must be enrolled within 31 days of birth.	No Charge No charge Inpatient Care \$15 Prenatal Care and First postpartum office 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/GLASSES Vision Service Plan: \$10 co-payment Examinations: every 12 months Lenses: every 12 months Frames: every 24 months	Covered through Vision Service Plan. \$15 co-payment eye examinations only through Kaiser.	Covered through Vision Service Plan. \$15 co-payment for examinations Kaiser provides \$150 allowance for one pair every two years. Contacts in lieu of glasses if medically necessary.	Covered through Vision Service Plan;
MENTAL HEALTH Outpatient Inpatient	 \$15 co-pay up to 20 visits per calendar year. (Severe mental illnesses covered as any other condition) Hospital covered in full up to 45 days per year.	 \$15 co-pay for unlimited visits. (Severe mental illnesses covered as any other condition) Hospital covered in full up to 45 days per year in addition to 190 plan days per lifetime as covered by Medicare.	[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 co-pay.

COVERAGE FEATURES	KAISER NON-MEDICARE	KAISER SENIOR ADVANTAGE	BLUE SHIELD NON MEDICARE
CHEMICAL DEPENDENCY <i>(Alcohol or drug abuse)</i>	No Charge for Inpatient Detox. \$15 Outpatient Visits \$5 Outpatient Group Visits \$100 Transitional Residential Recovery Services (up to 60 days per calendar year not to exceed 120 days in any 5 year period) <u>Alternatively, benefits are provided through the PacifiCare Behavioral Health substance Abuse Program</u> (see description under Indemnity Plan)	No Charge for Inpatient Detox. \$15 Outpatient Visits \$5 Outpatient Group Visits \$100 Transitional Residential Recovery Services (up to 60 days per calendar year not to exceed 120 days in any 5 year period) <u>Alternatively, benefits are provided through the PacifiCare Behavioral Health substance Abuse Program</u> (see description under Indemnity Plan)	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 inpatient. <u>Blue Shield covers medical acute detoxification the same as medical – no charge for inpatient hospitalization.</u>
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
PHYSICAL THERAPY	\$15 co-payment (short term)	\$15 co-payment (short term)	\$20 per visit (short term)
PRESCRIPTION DRUGS	\$10 (generic) \$20 (brand named) per prescription or refill at Kaiser Pharmacies up to a 100 day supply.	\$10 (generic) \$20 (brand named) per prescription or refill at Kaiser 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) per prescription or refill for a 90-day supply of mail order prescriptions. Home Self-injectable 20% up to \$100 co-pay maximum per prescription
PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT	No Charge.	No Charge.	Prosthetic & Orthotic – equipment & devices no charge with authorization. Durable medical equipment – no charge up to \$5,000 maximum per calendar year.
EMERGENCY CARE AND OUT OF SERVICE AREA <i>(Outside of Plan facilities)</i>	\$25 co-pay, waived if admitted. Worldwide coverage for Urgent and Emergency services. Follow-up Visits covered at Kaiser facility.	\$25 co-pay, waived if admitted. Worldwide coverage for Urgent and Emergency services. Follow-up Visits covered at Kaiser facility.	\$50 co-pay, 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 Unmarried children through age 18. Unmarried children 19 through 24 if full time students.	<u>Allergy testing:</u> \$15 co-payment /treatment \$3 co-pay Injections <u>Chiropractic:</u> Chiropractic covered at \$15 co-pay up to 30 visits in the calendar year. <u>Home Health:</u> Skilled nursing visits on intermittent basis - no charge when prescribed. <u>Facility:</u> Skilled Nursing/ 100 days per benefit period no charge if authorized.	<u>Allergy testing:</u> \$15 co-payment /treatment \$3 co-pay Injections <u>Chiropractic:</u> Chiropractic covered at \$15 co-pay up to 30 visits in the calendar year. <u>Home Health:</u> Skilled nursing visits on intermittent basis - no charge when prescribed. <u>Facility:</u> Skilled Nursing/100 days per benefit period no charge if authorized.	<u>Allergy testing:</u> \$20 co-pay for allergy testing, serum included. <u>Chiropractic:</u> Chiropractic and Acupuncture services not covered. <u>Facility:</u> Skilled nursing/100 days per year no charge if authorized. <u>Infertility treatment:</u> Testing paid at 50% of allowed charges. <u>Home health care:</u> Maximum of 100 days per calendar year.

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.