SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE TRUST

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ANNOUNCEMENT TO ALL PLAN PARTICIPANTS

The 2011 Open Enrollment Period Will be Held in July 2011 With Plan Enrollment Changes Taking Effect August 1, 2011

Please look for your Open Enrollment Packets to be distributed during the week of July 11th.

The Trustees met on May 17, 2011, and approved several changes to the Plan. First, however, the Trustees are pleased to report that the Plan remains in good financial position in spite of a significant drop in hours over the past few years. With the exception of the changes noted below, the Trustees approved the provider renewals with no changes in benefits. As of the Plan year ended January 31, 2011, the Plan's uncommitted reserves were $18,545,200, representing an equivalent of 9.3 months of benefits and operating expenses. The Plan is projected to continue to use some of its reserves to cover increasing health care costs during the current Plan year even after factoring in the hourly contribution increase of $0.75 that took effect June 1, 2011. The Trustees will continue to monitor the Plan closely and take action, as necessary, to keep the Plan healthy.

The Board of Trustees approved the following changes:

1) ***Change to Prescription Drug Plan Affecting Retirees in the Self Funded PPO Plan.*** The prescription drug plan will include a "step therapy" program for select drugs prescribed after July 31, 2011, under the self-funded PPO plan to retirees and their dependents. Generic and higher cost drugs prescribed before August 1, 2011, will not be affected by this change.

Step therapy is an automated program that a pharmacist uses to review a patient's medication history, often resulting in an alternative (sometimes generic) medication to replace a more costly medication. The program requires a patient to try a clinically appropriate, lower cost medication first, unless a physician provides medical documentation explaining why a patient is not a good candidate for the lower cost medication or therapy.

If a covered individual chooses not to participate in the step therapy program by purchasing the brand drug before trying the alternative, that individual will be required to pay the applicable copay plus the total cost difference between the brand and the alternative, unless clinical documentation from the prescribing physician indicates the lower cost medication is not a suitable substitute. A listing of the traditional generic step therapy classes with drugs that are currently subject to step therapy will be provided to all Self Funded PPO retirees at the end of the open enrollment period. This list is for informational purposes since there will be changes as new drugs are introduced and patents expire.

2) ***Increase in Monthly Co-Payment for Temporary Disability Coverage.*** The monthly co-payment for coverage provided under the Plan's Temporary Disability provision will increase from $125.00 to $145.00 per month effective August 1, 2011, for both new applicants and currently eligible participants.

3) ***Increase in Death Benefit for Active Participants.*** The lump sum survivor benefit for beneficiaries of participants who die while Active or pre-age 62 Early Retiree coverage is in force will increase from $40,000 to $50,000 ($80,000 to $100,000 for accidental deaths), effective for participants who die after July 31, 2011. The death benefit does not apply to deaths occurring as a result of suicide or self-inflicted injuries, or upon the death of pre-age 62 retirees who are covered under the Plan as a result of permanent disability.

4) ***Implementation of Disease and Complex Case Management Programs for PPO Plan.*** Disease and Complex Case Management programs have been in place for participants covered under the Kaiser and Blue Shield HMO Plans. Because these types of programs are so beneficial to individuals suffering from diseases and acute conditions, and have proven to reduce Plan costs over the long term, the Trustees decided to use reimbursements received from the Early Retiree Reinsurance Program to fund these programs for the PPO Plan. The disease management program includes personalized at-home monitoring of conditions such as asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure and coronary artery disease. The complex case management program provides a range of specialized services for individuals with multiple conditions, advanced-state cancer and acute circulatory or digestive conditions, as well as support for individuals and their families who face end of life hospice care. These programs are member friendly and not intended as a substitute for patient/provider communications. Participation is voluntary and participants may opt out at any time. More information regarding these programs will be provided at the end of the open enrollment period.

5) ***Changes to Mental Health and Substance Abuse Treatment Benefits.*** As a cost savings measure, the Trustees declined to renew the carved out Mental Health/Substance Abuse coverage available through OPTUM Health (formerly PacifiCare Behavioral Health) after reviewing OPTUM's 30% increase in its proposed renewal rate. In OPTUM's place, the Trustees agreed that mental health and substance abuse benefits will now be provided through the Blue Shield HMO, Kaiser, and the Self Funded PPO programs in which Participants are enrolled for other medical coverage. The following summarizes how this change will affect you, effective August 1, 2011, depending on the Plan program in which you are enrolled.

Kaiser Participants. Currently, Substance Abuse Treatment and Mental Health benefits are provided through Kaiser, with access to substance abuse treatment benefits and the Member Assistance Program (MAP) through OPTUM Health.

Effective August 1, 2011, Kaiser members will have both Substance Abuse Treatment and Mental Health benefits available only through Kaiser. They will no longer have access to the "MAP". This change will result in the loss of 100% in-network benefits as well as access to out-of-network treatment for Substance Abuse Treatment benefits for Kaiser enrollees. As a result, the Plan's Kaiser program will lose its grandfathered status under the Affordable Care Act (ACA) and, accordingly, also effective August 1, 2011, Kaiser will provide 100% preventive care coverage. You may obtain more information regarding this coverage at: http://www.healthcare.gov/law/about/provisions/services/lists.html.

Blue Shield HMO. Currently Substance Abuse Treatment and Mental Health benefits are provided only through OPTUM Health with access to OPTUM's Member Assistance Program (MAP).

Effective August 1, 2011, these benefits will be available only through Blue Shield. Blue Shield HMO participants have access to Blue Shield's Life Referrals 24/7, which is similar to the MAP available through OPTUM Health. This program allows members to access a 24/7 help line (800-985-2405) to speak with a mental health counselor, life coach, or even a financial advisor. As with regular medical benefits, HMO Participants will be required to use Blue Shield's network. The provider network that the Plan has been using under OPTUM is currently identical to Blue Shield's provider network. Thus, the Trustees believe there will be no disruption in coverage for participants who are being treated by an OPTUM Health provider. Although this program change will result in the loss of out-of-network access for both Substance Abuse Treatment and Mental Health benefits which in turn will result in the loss of grandfathered status under the ACA for the Blue Shield HMO program, Blue Shield is already in compliance with ACA's non-grandfathered plan requirements, including providing 100% preventive care coverage.

Self-Funded PPO Plan. Currently Substance Abuse Treatment and Mental Health benefits are provided only through OPTUM Health with access to their Member Assistance Program (MAP).

Effective August 1, 2011, Self Funded Plan participants will have access to Blue Shield's Life Referrals 24/7, which is similar to the MAP available through OPTUM Health. This program allows members to access a 24/7 help line (800-985-2405) to speak with a mental health counselor, life coach, or even a financial advisor. As with other self funded medical benefits, the Plan will use Blue Shield's PPO network, preauthorization, and case management services, and participants will continue to have access to out-of-network treatment. Because this change does not result in changes to the current Plan benefits for Self Funded PPO program participants, the Self-Funded program will retain its grandfather status. New Identification Cards will be provided to all Self Funded PPO Plan participants at the end of the open enrollment period.

6) ***New COBRA Rates.*** Early this year, active plan participants were notified that the direct self-pay provision was merged into COBRA continuation coverage to simplify administration of the Plan. The required payment was changed so that it would not exceed the lesser of 1) the COBRA rate based on the applicable premium and a 2% administrative charge, or 2) the former direct pay rate based on the hourly employer Plan contribution rate, multiplied by the number of hours required for one month of Plan coverage. The following table, reflects the Active Plan COBRA rates that will apply for coverage beginning August 1, 2011 and ending July 31, 2012:

Plan	COBRA Rate	COBRA with 65% Subsidy
PPO Plan - Medical Only	$1,196.67	$418.83
PPO Plan - Medical/Dental Vision	$1,368.00	$590.16
Kaiser Plan - Medical Only	$982.32	$343.81
Kaiser plus Dental & Vision	$1,153.66	$515.14
Blue Shield HMO - Medical Only	$1,196.67	$418.83
Blue Shield HMO plus Dental & Vision	$1,368.00	$590.16

The 65% COBRA subsidy shown above is pursuant to the American Recovery and Reinvestment Act (ARRA) enacted in 2009. The subsidy is available for up to a maximum of 15 months of coverage and generally applies only in the event of an involuntary termination of employment between September 1, 2008, and May 31, 2010. For more details on the COBRA subsidy, please refer to prior notices or ask the Plan Office.

The Self Funded PPO Plan is a "grandfathered health plan" under the ACA. As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Although being a grandfathered health plan means that the Plan is not required to include certain consumer protections of the ACA that apply to other plans (for example, the requirement for the provision of preventive health services without any cost sharing), the Plan must comply with certain other consumer protections in the ACA (for example the elimination of lifetime limits on benefits and extension of dependent coverage to adult children to age 26). In addition, the Plan provides health coverage benefits far beyond the "basic" level of benefits and has long maintained many consumer protections now required under the ACA (for example, it provides many preventive screening procedures at 100%, bans rescissions of coverage due to a member's health condition, exclusions for pre-existing conditions for children and adults, and "waiting periods" after a member attains initial coverage based on hours of work). Questions regarding which protections apply and which do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the contract plan administrator, EISB, at (415) 263-3670. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If you have any questions regarding the change in benefits described above, please contact EISB at (415) 263-3670.