

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE TRUST

720 MARKET STREET, SUITE 700 • SAN FRANCISCO, CA 94102
(415) 263-3670 • FAX (415) 263-3672

2011-2012 OPEN ENROLLMENT NOTICE

July 2011

TO: SAN FRANCISCO ELECTRICAL WORKERS RETIREE PLAN PARTICIPANTS
FROM: BOARD OF TRUSTEES
RE: OPEN ENROLLMENT- Plan selection for 8/1/2011 – 7/31/2012

The Open Enrollment is being held during the month of July for coverage effective August 1, 2011. **Depending on where you reside**, you may choose from the following medical plans:

- ♦ **SELF FUNDED PPO (see note below on grandfathered status)**
- ♦ **KAISER or KAISER SENIOR ADVANTAGE HMO**
- ♦ **BLUE SHIELD HMO**

A comparison of the more significant benefits offered by these Plans is enclosed for your information, along with the current monthly co-payment schedule. 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 29, 2011.

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 Self Funded PPO Plan, your claims will be processed as though you are covered by Medicare, even if you fail to sign up or you are treated by a non-Medicare certified provider. 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 Plan 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.

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.

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

PLAN and DEPENDENT 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

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

Medicare Retirees

- ☐ SELF-FUNDED PPO (AVAILABLE WORLD WIDE)
- ☐ KAISER SENIOR ADVANTAGE (CALIFORNIA ONLY - must reside within a 30 mile radius of a Kaiser facility)

If you have had a change in dependent status or wish to add an eligible dependent not currently enrolled in the Plan, please check the applicable box below:

- ☐ CHANGE IN DEPENDENT STATUS

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, 2011.]

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN
720 MARKET ST., STE 700
SAN FRANCISCO, CA 94102
Ph. (415) 263-3670 FAX (415) 263-3672

Retiree Co-Payment Schedule
(January 1, 2011-December 31, 2011)

Early Retirees (Age 55-62)	
Plan	Monthly Payment
Kaiser	1520.00
Blue Shield (HMO)	1515.00
Self Funded Plan (PPO)	2170.00

Early Retirees (Age 62-64) who will reach Full Retiree Membership status at age 65*	
Plan	Monthly Payment
Kaiser-Single	608.00
Kaiser-Family	912.00
Blue Shield (HMO)-Single	606.00
Blue Shield (HMO)-Family	909.00
Self Funded Plan (PPO)-Single	868.00
Self Funded Plan (PPO)-Family	1302.00

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

Early Retirees (Age 62-64) who will reach Full Retiree Membership status at age 62**	
Plan	Monthly Payment
Kaiser	460.00
Blue Shield (HMO)	460.00
Self Funded Plan (PPO)	460.00

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

Other Retiree Categories (All Plans)	
Age	Monthly Payment
Surviving Spouses and Under Age 65 Disabled Retirees	400.00
Over Age 65 retirees who attained, or will attain, age 75 on or after 1/1/2007	Single 170.00 Family 340.00
Retirees who attained Age 75 before 1/1/2007	0.00

SAN FRANCISCO ELECTRICAL WORKERS RETIREE HEALTH & WELFARE PLAN
2011-2012 COMPREHENSIVE MEDICAL BENEFITS SUMMARY

PRINCIPAL FEATURES	SELF FUNDED PPO PLAN
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.
BENEFITS/OUT OF POCKET MAXIMUMS	<u>In Network Providers:</u> All benefits paid at 80% of the PPO Contract Rate after satisfying deductible of \$100 per person/\$200 family. All covered benefits paid at 100% of the PPO Contract Rate after incurring \$1,500 per person in "out of pocket" covered expenses in a calendar year. <u>Out of Network Providers:</u> All benefits paid at 60% of usual and customary charges after satisfying deductible of \$100 per person/\$200 family. All covered benefits paid at 80% of usual and customary charges after incurring \$1,500 per person in "out of pocket" covered expenses in a calendar year.
HOSPITAL CONFINEMENT <i>(Room and board, surgery, anesthesia and miscellaneous)</i>	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums
DOCTOR VISITS – Office/Hospital	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums
OUTPATIENT LAB & X-RAYS	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums
OUTPATIENT SURGICAL & EMERGENCY ROOM SVCS	First \$5,000 paid at 100% (in network), 80% (Out of network) ; After first \$5,000, See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums
PREVENTATIVE HEALTH CARE <i>(Routine checkups, well baby care, immunizations, pap smears, etc.).</i>	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums for: Annual Physical- up to \$300 maximum, Preventative care & immunizations. Pays 100% for: Pap Smear & pelvic exam, Mammography Screening (some age based limitations), Colonoscopy, Flexible sigmoidoscopy, Fecal occult blood test, Prostate Cancer Screening.
EMPLOYEE ASSISTANCE PROGRAM (EAP)	Life Referrals (800) 985-2405; 3 Complimentary counseling sessions; Parenting/Childcare; Legal Advice; Financial Advice, Eldercare, etc.
AMBULANCE SERVICES	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums ; payable 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 Newborn Care	(Members and Spouses/Domestic Partners only) See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums Same as hospital confinement coverage shown above, for 48 hours following normal vaginal delivery and 96 hours following delivery by caesarian section. Well Baby covered while mother is confined
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 /SUBSTANCE ABUSE TREATMENT .	In Network: 100% of the PPO Contract Rate; See Benefits for Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums . Effective 8/1/2011: Coverage no longer insured through Optum Health (formerly PacifiCare Behavioral Health). Coverage now available directly through the Self Funded PPO Plan.
PHYSICAL THERAPY	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums ; Services subject to medical review for determination of medical necessity and appropriate treatment frequency.
PRESCRIPTION DRUGS	Administered through CVS/Caremark. Individual responsible for 20% co-payment (maximum co-pay for generics of \$7 retail and \$17.50 mail order) payable to pharmacy at time prescription is filled. For certain select drugs prescribed after 8/1/2011, Step therapy program requires purchase of lower cost medication before trying a brand drug; otherwise, participant 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.
PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums ; Rental of durable medical equipment, not to exceed the purchase price
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 Out Patient Surgical & Emergency Room SVCS described above
DENTAL COVERAGE	Covered by Delta Dental.
SPECIAL NOTES Your eligible dependents are: - Lawful Spouse, Registered Domestic Partner, Natural/Step/ Adopted Children through age 18; Adult Children ages 19 through 25	Chiropractic & Acupuncture treatments covered as any other medical expense, limited to 30 visits per calendar year. Self-Funded PPO Plan payments are based on allowable charges. Blood donations for your own surgery covered if physician recommends.
MEDICARE ELIGIBLE RETIREES AND DEPENDENTS	The Plan will offset covered charges by the amount payable by Medicare, even if a Medicare eligible retiree or dependent fails to enroll or is treated by a non-Medicare certified provider.

NOTE: This comparison of benefit coverage is intended only as a general description of the principal features of the benefit plans. Each Plan's benefit booklet should be consulted for additional information.

SAN FRANCISCO ELECTRICAL WORKERS RETIREE HEALTH & WELFARE PLAN
2010-2011 HEALTH MAINTENANCE ORGANIZATIONS COMPARISON OF BENEFITS SUMMARY

PRINCIPAL FEATURES	KAISER NON-MEDICARE	KAISER PERMANENTE SENIOR ADVANTAGE (Medicare Advantage Plan)	BLUE SHIELD HMO 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	\$100 per confinement
DOCTOR VISITS Office Hospital	\$20 per visit No charge	\$20 per visit No charge	\$25 per visit No charge
OUTPATIENT LAB & X-RAYS	No charge	No charge	No charge
OUTPATIENT SURGERY	\$20 per procedure	\$20 per procedure	\$50 per surgery
PREVENTATIVE HEALTH CARE <i>(Routine checkups, well baby care, immunizations, pap smears, etc.).</i>	No Charge	No Charge	No Charge
AMBULANCE SERVICES	No charge if authorized and medically necessary.	No charge if authorized and medically necessary.	No charge
MATERNITY CARE Mother's Expenses Newborn Care	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 Inpatient Care \$5 Prenatal Care and First postpartum office visit No charge in hospital. Newborns must be enrolled within 31 days of birth.	Inpatient: \$100 Co-pay Pre/Post Natal Care- No charge. No charge in hospital. Newborns must be 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. \$20 co-payment eye examinations only through Kaiser.	Covered through Vision Service Plan. \$20 co-payment for examinations Kaiser provides \$150 eyewear allowance for one pair every 24 months. Contacts in lieu of glasses if medically necessary.	Covered through Vision Service Plan.
MENTAL HEALTH	Outpatient: \$20 co-pay for individual visits. \$10 co-pay for group visits. Inpatient: Hospital covered in full.	Outpatient: \$20 co-pay for individual visits. \$10 co-pay for group visits. Inpatient: Hospital covered in full.	Effective 8/1/2011: Coverage no longer insured through Optum Health (formerly PacifiCare Behavioral Health). Coverage now available directly through the Blue Shield HMO Plan Outpatient: \$0 Copay In Patient: \$0 Copay

PRINCIPAL FEATURES	KAISER NON-MEDICARE	KAISER PERMANENTE SENIOR ADVANTAGE (Medicare Advantage Plan)	BLUE SHIELD HMO NON MEDICARE
SUBSTANCE ABUSE TREATMENT <i>(Alcohol or drug abuse)</i>	No Charge for Inpatient Detox. \$20 Outpatient Visits \$5 Outpatient Group Visits	No Charge for Inpatient Detox. \$20 Outpatient Visits \$5 Outpatient Group Visits	Effective 8/1/2011: Coverage no longer insured through Optum Health (formerly PacifiCare Behavioral Health). Coverage now available directly through the Blue Shield HMO Plan Outpatient: \$0 Copay In Patient \$0 Copay
EMPLOYEE ASSISTANCE PROGRAM (EAP)	Not Available	Not Available	Life Referrals (800) 985-2409; 3 Complimentary counseling sessions; Parenting/ Childcare; Legal Advice; Financial Advice; Eldercare, etc.
PHYSICAL THERAPY	\$20 co-payment (short term)	\$20 co-payment (short term)	\$25 per visit (short term)
PRESCRIPTION DRUGS	\$10 (generic) \$30 (brand named) per prescription or refill at Kaiser Pharmacies up to a 30 day supply. \$20 (generic) \$60 (brand named) per prescription or refill for a 90 day supply of mail order only.	\$10 (generic) \$25 (brand named) per prescription or refill at Kaiser Pharmacies up to a 30 day supply. \$20 (generic) \$60 (brand named) per prescription or refill for a 90 day supply of mail order only.	\$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 in accord with Kaiser Permanente's durable medical equipment formulary guidelines.	No Charge in accord with Kaiser Permanente's durable medical equipment formulary guidelines.	Prosthetic & Orthotic – equipment & devices no charge with authorization. Durable Medical Equipment- no charge
EMERGENCY CARE AND OUT OF SERVICE AREA <i>(Outside of Plan facilities)</i>	\$50 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. 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, Registered Domestic Partner, Natural/Step/ Adopted Children through age 18; Adult Children ages 19 through 25.	<u>Allergy testing:</u> \$20 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-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> \$25 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> Diagnosis and treatment of Causes of Infertility paid at 50% of allowed charges.(Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT) <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 principal features of the benefit plans. Each Plan's benefit booklet should be consulted for additional information.

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ANNUAL NOTICE

[This information is included in your Summary Plan Description]

Women's Health and Cancer Rights Act of 1998

On October 21, 1998, President Clinton Signed the Omnibus Appropriations Bill which included a new federal law called the Women's Health and Cancer Rights Act of 1998. Under this new federal law, group health plans, group health plans, insurers and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending physician and the patient, for 1) reconstruction of the breast on which the mastectomy was performed, 2) surgery and reconstruction on the other breast to produce a symmetrical appearance, and 3) prostheses and physical complications of all stages of mastectomy, including lymphedemas. This coverage is subject to the plan's annual deductibles and coinsurance provisions.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connections with childbirth for the mother or newborn child less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. (However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother her newborn earlier than the 48 hours, or 96 hours as applicable.) In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

If you have any questions concerning these matters, please contact the Fund Office at (415) 263-3670.