SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN
2018-2019 COMPARISON OF BENEFITS SUMMARY

PRINCIPAL FEATURES	COMPREHENSIVE MEDICAL COVERAGE	HEALTH MAINTENANCE ORGANIZATIONS	
	SELF-FUNDED PPO Coverage Worldwide	**KAISER PERMANENTE**	**BLUE SHIELD HMO**
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.
ANNUAL PLAN MAXIMUMS	No annual maximum effective 1/1/2014.	No plan maximum.	No plan maximum.
BENEFITS/ OUT OF POCKET MAXIMUMS	**In Network Providers**: All benefits paid at 80% of the PPO Contract rate after satisfying deductible of $150 per person/$300 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. **Out of Network Providers**: All benefits paid at 60% of usual and customary charges after satisfying deductible of $150 per person/$300 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.	Maximum Out of Pocket: $1,500 Individual $3,000 Family See Co-pay information under categories listed below.	Maximum out of Pocket: $2,000 individual $4,000 two-party $6,000 family See Co-pay information under categories listed below.
HOSPITAL CONFINEMENT Room and Board, surgery, anesthesia and miscellaneous	See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums.**	No charge	$100 Co-pay
DOCTOR VISITS Office Hospital	See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums.**	$20 per visit No charge	$25 per visit No charge
OUTPATIENT LAB & X-RAYS	See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums**	No charge	No charge
OUTPATIENT SURGICAL SERVICES	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.**	$20 per procedure	$50 per surgery
PREVENTIVE HEALTH CARE	In Network 100% coverage for preventive care treatment, as required under PPACA. Information regarding services that are covered is available at: http//www.healthcare.gov/law/about/provisions/services/lists.html; 60 % out of network coverage for limited preventive care services.	No Charge; includes all preventive services mandated under the Affordable Care Act.	No Charge; includes all preventive services mandated under the Affordable Care Act.
AMBULANCE SERVICES	See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums**. Coverage available 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 Expenses Newborn Care	**(Members & Spouses/Domestic Partners only)** Same as hospital confinement shown above for 48 hours following vaginal delivery and 96 hours following deliver by caesarian section. See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums.**	No charge $5 Prenatal Care & First Post Partum Visit No charge in hospital. Well newborns must be **enrolled within 31 days of birth.**	In patient:: $100 Co-pay Pre/Post Natal Care: 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.	$20 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.

OVER

COVERED FEATURES	COMPREHENSIVE MEDICAL COVERAGE	HEALTH MAINTENANCE ORGANIZATIONS	
	SELF-FUNDED PPO (Coverage Worldwide)	**KAISER PERMANENTE**	**BLUE SHIELD HMO**
MENTAL HEALTH	In Network: 100% of Contract Rate. See Benefits for Out of Network Treatment Described under **Benefits/Out-Of Pocket Maximums.**	Outpatient: $20 co-pay for Individual Visits $10 co-pay for Group Visits Inpatient: Hospital covered in full	$0 Co-pay per out patient treatment $0 Co-pay per in patient confinement
SUBSTANCE ABUSE TREATMENT *(Alcohol and Drug dependency)*	In Network: 100% of Contract Rate. See Benefits for Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums.	No Charge for inpatient Detox. $20 Outpatient Visits. $5 Outpatient Group Visits.	$0 Co-pay per out patient treatment $0 Co-pay per in patient confinement;
PHYSICAL THERAPY	See Benefits for In and Out of Network Treatment Described under **Benefits/Out-Of Pocket** Maximums; Claims subject to peer review for medical necessity and determination of appropriate treatment.	$20 Co-pay (short term)	Short-term therapy $25 copay.
EMPLOYEE ASSISTANCE PROGRAM (EAP)	Life Referrals (800) 985-2405; 3 Complimentary counseling sessions; Parenting/Childcare; Legal Advice; Financial Advice, Eldercare, etc.	Not Applicable	Life Referrals (800) 985-2405; 3 Complimentary counseling sessions; Parenting/Childcare; Legal Advice; Financial Advice, Eldercare, etc.
PRESCRIPTION DRUGS	Administered through OptumRX. Individual responsible for 20% co-payment (maximum co-pay for generics of $7 retail and $17.50 mail order), Preferred Brand Drugs and Non-Preferred Brand Drugs 20% co-payment, and High Cost Drugs 20% co-payment (maximum $150) payable to pharmacy at time prescription is filled. For certain select drugs, Step therapy program requires purchase of lower cost medication before trying a brand drug; otherwise, participant will be required to pay the applicable co-pay 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.	$10 generic/$30 brand named per prescription or refill at Kaiser Permanente Pharmacies up to a 30-day supply. $20 generic/$60 brand 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) 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	See Benefits for In and Out of Network Treatment Described under **Benefits/Out of Pocket Maximums**. Rental of medical equipment, not to exceed the purchase price.	No charge in accord with Kaiser Permanente's durable medical equipment formulary guidelines	Prosthetics & Orthotics equipment and devices no charge. Durable Medical Equip. no charge.
EMERGENCY ROOM AND OUT OF AREA SERVICE *(Outside of Plan facilities)*	Worldwide Coverage. In Network: First $5,000 paid at 100%. After first $5,000, See Benefits for In and Out of [Network Treatment due to serious threat of health as defined by PPACA is covered without regard to whether a provider is in or out-of-network]	$100 Co-pay. Worldwide coverage for urgent or emergency services. Follow-up and routine care covered at Kaiser facility. Waived if admitted directly to hospital.	$100 copay, waived if admitted to hospital. Routine care not covered.
DENTAL COVERAGE	Self Funded Plan Administered by Delta Dental.	Self Funded Plan Administered by Delta Dental.	Self Funded Plan Administered 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 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 calendar year. Acupuncture services are not covered. $20 per Visit Allergy and/or Testing $3 Allergy Injection Visits	Chiropractic and Acupuncture services not covered. $25 per visit for allergy testing, allergy serum is included. Home health care maximum of 100 visits per calendar year. Diagnosis and treatment of Causes of Infertility paid at 50% of allowed charges. (Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT.)

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 HEALTH & WELFARE TRUST

720 MARKET STREET , SUITE 700 • SAN FRANCISCO, CA 94102
(415) 263-3670 • FAX (415) 263-3674

June 29, 2018

TO: Active Participants in SFEW Health & Welfare Plan

FROM: Board of Trustees of the San Francisco Electrical Workers Health & Welfare Plan

RE: Orthodontic Benefits

The San Francisco Electrical Workers Health & Welfare Board of Trustees approved increasing the lifetime orthodontic benefit for participants with active coverage to $6,000 per person effective March 1, 2018. Those currently in orthodontic treatment will be grandfathered and allowed to receive the new lifetime maximum.

Enclosed in the packet is the updated Delta Dental benefit highlight sheet for division 04874-01005 which shows the new $6,000 orthodontic lifetime maximum.

Plan Benefit Highlights for: San Francisco Electrical Workers Health & Welfare Plan (Active)

Group No: 04874 - 01005

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month that dependent turns age 26			
Deductibles	None			
Maximums	$4,000 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	**Delta Dental PPO dentists****	**Non-Delta Dental PPO dentists****
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	100 %
Basic Services Fillings, posterior composites and sealants	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	80 %	80 %
Prosthodontics Bridges, dentures and implants	80 %	80 %
Orthodontic Benefits Adults and dependent children	80 %	80 %
Orthodontic Maximums	$6,000 Lifetime	$6,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
800-765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

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**** NEW HEALTH CARE PLAN BENEFIT ****

June 29, 2018

TO: Local 6 Members Participating in SFEW Health & Welfare Plan
FROM: Board of Trustees of the San Francisco Electrical Workers Health & Welfare Plan
RE: New Health Reimbursement Arrangement (HRA) Benefit

Beginning with hours worked in June 2018, $0.25 per hour is being contributed by your Employer to an account established on your behalf under a new Health Reimbursement Arrangement that was recently added to the Plan. All active Local 6 members eligible for major medical coverage are eligible for this new benefit.

What is a Health Reimbursement Arrangement?

A Health Reimbursement Arrangement ("HRA") allows a health plan participant to maintain an employer-funded account alongside major medical coverage. The participant may use that account to pay for qualified out-of-pocket medical expenses incurred by the participant and his or her spouse and dependents. Qualified medical expenses are described in detail in IRS publication 502. (See https://www.irs.gov/pub/irs-pdf/p502.pdf.) Unused HRA account balances accumulate and carry over from one year to the next. In addition, accounts can still be used after your employment terminates, before or after retirement.[1]

Your Account Will be Available to You on January 1, 2019[2]

Beginning January 1, 2019, you may request reimbursement by filing a paper claim form for any unreimbursed health care expenses you incurred after May 31, 2018. Out-of-pocket health care expenses you incur on or after January 1, 2019, may be claimed either by filing a paper claim form or by charging the expense to a debit card ("Health Debit Card") issued to you that will be linked to your HRA account. Either payment method will require you to retain documentation of the medical expenses you incur.

HRA account statements will be mailed to you on a quarterly basis, though you may track your contribution credits and reimbursement charges via website at any time.

Additional information explaining the reimbursement process and other features of this new program will be mailed to you in the coming months.

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[1] Unused account balances may be subject to forfeiture due to, for example, the participant's death with no surviving dependent or voluntary waiver of the benefit after termination to qualify for health care subsidies.

[2] Your HRA account will begin to fund starting June 1, 2018 and be credited based on hours you work. All HRA contributions that accrue during the period between June 1, 2018, and December 31, 2018, will be credited to your account so that the funds will be available on January 1, 2019.

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SECTION 1: PARTICIPANT ENROLLMENT INFORMATION					
Check One: ☐ Initial Enrollment ☐ Change in Enrollment Status					
Soc. Sec. No.		Birth Date			
Last Name		First Name		M. Inl.	
Address					
City		State		Zip Code	
Phone Number		E-Mail Address			
Marital Status	☐ Single ☐ Married ☐ Registered Dom. Partner ☐ Widowed ☐ Divorced		Gender	☐ Female ☐ Male	
Plan Selection*	☐ Self Funded PPO ☐ Kaiser ☐ Blue Shield HMO				

*Note: If this is not an initial enrollment, no change in plan selection may be made until the Plan's Open Enrollment Period. To enroll in Blue Shield HMO or Kaiser, you must live in Blue Shield or Kaiser's service area and file the appropriate form with this office.

SECTION 2: SPOUSE/DOMESTIC PARTNER** ENROLLMENT INFORMATION (Complete If You are Married or have a Registered Domestic Partnership)					
Soc. Sec. No.		Birth Date			
Last Name		First Name		M. Inl.	
Spouse's Employer		Phone			
Is medical coverage available through your spouse's employment? ☐ Yes ☐ No ☐ Unemployed If yes, did your spouse elect to be covered under her employer's plan? ☐ Yes ☐ No If yes, provide information below.					
Name of Insurance		Effective Date			
Address			Phone		
Does your Spouse/Partner's insurance provide coverage for dependent children? ☐ Yes ☐ No If Yes, is coverage provided for Adult Child(ren) listed in Section 4? ☐ Yes ☐ No					

**Note: Domestic Partner Coverage may be considered imputed income for Federal and/or State taxes purposes, and be subject to advance payment of Federal and/or State Payroll taxes as a condition of enrollment.

SECTION 3: UNDER AGE 19 CHILD ENROLLMENT INFORMATION
(If applicable, list Adult Children Age 19 through Age 25 in Section 4 on the Back Page)

Soc. Sec. No.	Last Name, First Name	Birth Date	Gender	Relationship***

***1) Natural Child; 2) Step Child; 3) Adopted Child; 4) Child of Domestic Partner; 5) Child by Legal Guardianship

I certify the accuracy of the above information and understand that I must inform the Plan Office of any changes	
Participant's Signature	Date Signed

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An Adult Child age 19 through age 25 may be eligible for coverage on the same basis as dependent children under the Plan provided the Adult Child is not eligible to enroll in group medical insurance other than through a plan that covers the other parent. [Note: this "other coverage" rule will no longer apply when/if the Plan loses grandfather status.]

SECTION 4: ADULT CHILD (Age 19 through Age 25) ENROLLMENT INFORMATION						
Adult Child		Birth Date		Soc. Sec. No.		
Adult Child Address						
Is this adult child employed? ☐ Yes ☐ No	If Yes, Provide Name and Address of Employer:					
Does this adult child have medical insurance available (even if not elected) through his/her employment? ☐ Yes ☐ No	If Yes: Name/Address of Insurance					
	Phone No.		Policy No.		Effective Date	
Is other Medical Insurance available through a Parent other than the above-named Participant? ☐ Yes ☐ No	If Yes: Parent's Name				Soc. Sec. No.	
	Name/Address of Insurance					
	Phone No.		Policy No.		Effective Date	
Is other Medical Insurance available (even if not elected) through the spouse of the Adult Child? ☐ Yes ☐ No ☐ Not Married	If Yes: Spouse's Name				Soc. Sec. No.	
	Name/Address of Insurance					
	Phone No.		Policy No.		Effective Date	

(A Separate Form Must Be Completed For Each Adult Child Enrollment Request)

PARTICIPANT CERTIFICATION REQUIRED TO REQUEST COVERAGE		
I certify the accuracy of the above information and choose to elect coverage on the indicated Adult Child. I understand that I must inform the Plan Office of any changes in Adult Dependent Status. In understand that I will be responsible for any overpayments that occur if a status change occurs and the Plan Office is not notified.		
Participant Name (Print):	Date:	Phone:
Participant Signature:		Participant SSN:

DOCUMENTS REQUIRED FOR ENROLLMENT

Please provide copies of any applicable documentation as outlined below.

ENROLLING THE PARTICIPANT:

- ❑ Complete Section 1 on the Enrollment Form.

ENROLLING SPOUSE:

- ❑ Complete Section 2 on the Enrollment Form.
- ❑ Marriage Certificate

ENROLLING REGISTERED DOMESTIC PARTNER

- ❑ Complete Section 2 on the Enrollment Form
- ❑ State or County Registration of Domestic Partnership
- ❑ Complete Declaration of Domestic Partnership
- ❑ If Partner is claimed as a Dependent for Income Tax Purposes, Complete Affidavit of Dependency For Tax Purposes
- ❑ If Partner is not claimed as a Dependent for Income Tax Purposes, advance payment of required payroll taxes. (Plan Office will provide this information upon receipt of completed Declaration of Domestic Partnership.)

ENROLLING ONE OR MORE CHILDREN THROUGH AGE 18

- ❑ Complete Section 3 on the Enrollment Form and include copies of any applicable documents below.

Natural Child

- ❑ Birth Certificate of Child

Dependent Child from Previous Marriage

- ❑ Birth Certificate of Child
- ❑ Divorce Decree & Settlement of prior marriage

Step Child or Child of Domestic Partner

- ❑ Birth Certificate of Child
- ❑ Name of other legal parent, including information regarding any other insurance coverage.

Child for Which Participant is Guardian

- ❑ Birth Certificate of Child
- ❑ Guardianship/Custody documents

Adopted Child

- ❑ Birth Certificate of Child
- ❑ Final Adoption Order or copy of Placement Agreement if the adoption is not yet final.

Child Born Outside of Marriage

- ❑ Birth Certificate of Child
- ❑ Court Order Regarding Insurance (Qualified Medical Child Support Order "QMSCO")
- ❑ Name of other legal parent, including information regarding any other insurance coverage.

ENROLLING ONE OR MORE CHILDREN AGE 19 THROUGH AGE 25

- ❑ Complete Section 4 on the Enrollment Form
- ❑ Birth Certificate of Child

Important Note: If you have a family member who qualifies as a Dependent under the Plan, you may enroll your Dependent in the Plan only: (i) when you first enroll for coverage, (ii) during open enrollment periods (which usually occur during the month of July with changes effective August 1), or (iii) within 30 days of when the family member first becomes a dependent. If your coverage lapses during open enrollment and you re-establish your eligibility, you may enroll your Dependents within 30 days of the date you re-established your eligibility under the Plan. All of your Dependents are covered by the same option that covers you, if they are properly enrolled in the Plan. No benefits are payable for any person who is not properly enrolled (except that the Plan's Special Enrollment Provision may allow delayed enrollment under limited circumstances).