SAN FRANCISCO ELECTRICAL WORKERS RETIREE HEALTH & WELFARE PLAN
2017-2018 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 *Room and board, surgery, anesthesia and miscellaneous*	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
PREVENTIVE HEALTH CARE *(All preventive screenings mandated by the Affordable Care Act).*	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.	Outpatient: $0 Co-pay In Patient: $0 Co-pay

PRINCIPAL FEATURES	KAISER NON-MEDICARE	KAISER PERMANENTE SENIOR ADVANTAGE (Medicare Advantage Plan	BLUE SHIELD HMO NON MEDICARE
SUBSTANCE ABUSE TREATMENT (*Alcohol or drug abuse)*	No Charge for Inpatient Detox. $20 Outpatient Visits $5 Outpatient Group Visits	No Charge for Inpatient Detox. $20 Outpatient Visits $5 Outpatient Group Visits	Outpatient: $0 Co-pay In Patient $0 Co-pay
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 (*Outside of Plan facilities*)	$100 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.	$100 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.	Allergy testing: $20 co-payment /treatment $3 co-pay Injections Chiropractic: Chiropractic covered at $15 co-pay up to 30 visits in the calendar year. Home Health: Skilled nursing visits on intermittent basis - no charge when prescribed. Facility: Skilled Nursing/ 100 days per benefit period no charge if authorized.	Allergy testing: $20 co-payment /treatment $3 co-pay Injections Chiropractic: Chiropractic covered at $15 co-pay up to 30 visits in the calendar year. Home Health: Skilled nursing visits on intermittent basis - no charge when prescribed. Facility: Skilled Nursing/100 days per benefit period no charge if authorized.	Allergy testing: $25 co-pay for allergy testing, serum included. Chiropractic: Chiropractic and Acupuncture services not covered. Facility: Skilled nursing/100 days per year no charge if authorized. Infertility treatment:: Diagnosis and treatment of Causes of Infertility paid at 50% of allowed charges.(Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT) Home health care: 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.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.eisb.org** or by calling **415-263-3670**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$150** per person **$300** per family Does not apply to: preventive care; first $5,000 of out-patient Hospital charges (see plan for requirements); early screenings; and prescription drugs. Copayments do not count toward the deductible.	You must pay all the costs up to the **deductible** amount before this Plan begins to pay for covered services you use. Check your Plan Document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this Plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For **$1,500** per person in Covered Charges	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Deductibles, balance-billed charges, and health care this Plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No annual limit effective January 1, 2014**	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.blueshieldca.com or call 1-800-541-6652 for a list of participating providers	If you use an in-network doctor or other health care **provider**, this Plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this Plan pays different kinds of providers.

Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this Plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this Plan doesn't cover are listed on page 4. See your Plan Document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **Preferred Providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Amount in excess of Reasonable and Customary charge is not covered.
	Specialist visit	20% coinsurance	40% coinsurance	
	Other practitioner office visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/immunization	No charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Amount in excess of Reasonable and Customary charge is not covered.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Optumrx.com.	Generic drugs	Lesser of 20% of retail price or $7/script (pharmacy); $17.50/script (mail order)	40% coinsurance	Covers up to 30-day supply (retail pharmacy); Covers up to 90-day supply (mail order)
	Brand Name drugs	20% of retail price	40% coinsurance	
	Specialty drugs	20% coinsurance up to $150	40% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	If required, your cost for out-patient **Hospital facility** charges will be $0 for the first $5,000. Amount in excess of Reasonable and Customary charge is not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance	40% coinsurance	Out-of-network at 20% if treatment is required due to a serious threat to health Amount in excess of Reasonable and Customary charge is not covered.
	Emergency medical transportation	20% coinsurance	40% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Amount in excess of Reasonable and Customary charge is not covered.
	Physician/surgeon fee	20% coinsurance	40%coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	40% coinsurance	Amount in excess of Reasonable and Customary charge is not covered.
	Mental/Behavioral health inpatient services	No charge	40% coinsurance	
	Substance use disorder outpatient services	No charge	40% coinsurance	
	Substance use disorder inpatient services	No charge	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Only covered for Participant, Spouse, or Domestic Partner, not Dependent

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Child. Amount in excess of Reasonable and Customary charge is not covered.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Amount in excess of Reasonable and Customary charge is not covered.
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	After in-patient Hospital confinement of 3+ days, covers up to 100 days less days of Hospital confinement.
	Durable medical equipment	20% coinsurance	40% coinsurance	Covers rental not to exceed purchase price.
	Hospice service	20% coinsurance	40% coinsurance	Amount in excess of Reasonable and Customary charge is not covered.
If your child needs dental or eye care	Eye exam	$10 copayment	Cost in excess of $45	none
	Glasses	$10 copayment	Cost in excess of $45-$85 (lenses) & $47 (frames)	Covers lenses every 12 months and frames every 24 months.
	Dental check-up	No charge	20% coinsurance	20% coinsurance only applicable to Retirees

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your Plan Document for other excluded services.)

- Charges in excess of Reasonable and Customary
- Cosmetic Surgery
- Experimental or not generally accepted treatment
- Infertility treatment
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine foot care
- Treatment not medically necessary
- Weight loss programs
- Non-emergency care when traveling outside the U.S.

Other Covered Services (This isn't a complete list. Check your Plan Document for other covered services and your costs for these services.)

- Acupuncture (limit 30 visits/year)
- Bariatric surgery
- Chiropractic care (limit 30 visits/year)
- Coverage provided outside the United States. See www.bcbs.com
- Dental care
- Routine eye care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 415-263-3670. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Plan at 415-263-3670. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this Plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,920
- **Patient pays** $1,620

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$150
Copays	$0
Coinsurance	$1,470
Limits or exclusions	$0
Total	**$1,620**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,220
- **Patient pays** $1,180

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$150
Copays	$0
Coinsurance	$1030
Limits or exclusions	$0
Total	**$1,180**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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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 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 Your 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 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).