SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN
2017-2018 COMPARISON OF BENEFITS SUMMARY

	COMPREHENSIVE MEDICAL COVERAGE	HEALTH MAINTENANCE ORGANIZATIONS	
PRINCIPAL FEATURES	**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.

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 PLAN
720 MARKET ST., STE. 700
SAN FRANCISCO, CA 94102
Ph. (415) 263-3670 Fx. (415) 263-3672

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).

San Francisco Electrical Workers Health & Welfare Trust
❖❖Notice of Privacy Practices❖❖

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION

The San Francisco Electrical Workers Health & Welfare Trust ("the Health Plan") may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Health Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment. The Health Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Health Plan may use or disclose health information for its own operations to facilitate the administration of the Health Plan and as necessary to provide coverage and services to all of the Health Plan's participants. Health care operations may include such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Health Plan, including customer service and resolution of internal grievances.

For example, the Health Plan may use your health information to conduct case management, quality improvement and utilization review, or to engage in customer service and grievance resolution activities.

For Treatment Alternatives. The Health Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The Health Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

For Disclosure to the Plan Sponsor. The Health Plan may disclose your health information to the Board of Trustees for plan administration functions performed by the Board of Trustees on behalf of the Health Plan. In addition, the Health Plan may provide summary health information to the Board of Trustees so that the Board of Trustees may solicit premium bids from health insurers or modify, amend or terminate the plan. The Health Plan also may disclose to the Board of Trustees information on whether you are participating in the health plan.

When Legally Required. The Health Plan will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities. The Health Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action, or other activities necessary for appropriate oversight of government benefit programs (such as investigations of Medicare fraud).

Lawsuits and Similar Proceedings/Subpoenas. As permitted or required by state law, the Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only if the Health Plan has evidence or information such as a proof of service that you or your attorney received notice of the subpoena, discovery request or other lawful process (or the Health Plan has otherwise notified or attempted to notify you).

For Law Enforcement Purposes. As permitted or required by state law, the Health Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Health Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In the Event of a Serious Threat to Health or Safety. The Health Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Health Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious threat to your health or safety or to the health and safety of the public.

Military and Other Specified Government Functions. In certain circumstances, federal regulations require the Health Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Worker's Compensation. The Health Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Health Plan will not disclose your health information other than with your written authorization. If you authorize the Health Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Health Plan maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Health Plan's disclosure of your health information to someone involved in the payment of your care. The Health Plan is not required to comply with the agreed upon restriction(s) in emergency situations when the restricted PHI is needed for treatment. Additionally, the Health Plan is not required to agree to your request. If you wish to make a request for restrictions, please make your request in writing to the Health Plans "Privacy Official" at 720 Market St., Suite 700, San Francisco, CA 94102 or Fax to (415) 263-3674. For your convenience a "Request for Restrictions" Form is available.

Right to Receive Confidential Communications. You have the right to request that the Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Health Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Health Plans "Privacy Official" at 720 Market St., Suite 700, San Francisco, CA 94102 or Fax to (415) 263-3674. For your convenience a "Request for Confidential Communications" form is available. The Health Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Health Plans "Privacy Official" at 720 Market St., Suite 700, San Francisco, CA 94102 or Fax to (415) 263-3674. If you request a copy of your health information, the request must be made in writing to the Health Plans "Privacy Official", the Health Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A one-time 30 day extension may be necessary in unique circumstances. Please note that under government regulations, you do not have a right to copies of psychotherapy notes.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Health Plan amend the records. That request may be made as long as the information is maintained by the Health Plan. A request for an amendment of records must be made in writing to the Health Plans "Privacy Official" at 720 Market St., Suite 700, San Francisco, CA 94102 or Fax to (415) 263-3674. The Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Health Plan, if the health information you are requesting to amend is not part of the Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Health Plan determines the records containing your health information are accurate and complete.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures of your health information that the Health Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the Health Plans "Privacy Official" at 720 Market St., Suite 700, San Francisco, CA 94102 or Fax to (415) 263-3674. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003 and may not be made for periods of time going back more than six (6) years. The Health Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Health Plan will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Health Plans "Privacy Official" at (415) 263-3670. [You also may obtain a copy of the current version of the Health Plan's Notice at its Web site, *www.eisb.org*]

DUTIES OF THE HEALTH PLAN

The Health Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Health Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Health Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Health Plan changes its policies and procedures, the Health Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.

RIGHT TO FILE A COMPLAINT

You have the right to express complaints to the Health Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Health Plan should be made in writing to the Health Plans "Privacy Official" at 720 Market St., Suite 700, San Francisco, CA 94102 or Fax to (415) 263-3674. The Health Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Health Plan has designated the Health Plans "Privacy Official" as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at 720 Market St., Suite 700, San Francisco, CA 94102 or (415) 263-3670.

APPEALS PROCESS

If the Privacy Official or any other plan representative denies any request of takes other action (or fails to take such actions) with respect to this Privacy Notice and your Privacy Rights under the plan, you may submit a written appeal to the Board of Trustees in accordance with the appeal procedures set forth in the Plan's Summary Plan Description.

EFFECTIVE DATE[1]

This Notice is effective April 14, 2003.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT THE HEALTH PLANS "PRIVACY OFFICIAL" AT 720 MARKET ST., SUITE 700, SAN FRANCISCO, CA 94102 OR (415) 263-3670.

[1] Reviewed/Revised 06/2016

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

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.