SAN FRANCISCO ELECTRICAL WORKERS
HEALTH & WELFARE TRUST
720 MARKET STREET, SUITE 700 • SAN FRANCISCO, CA 94102
(415) 263-3670 • FAX (415) 263-3672

2012-2013 OPEN ENROLLMENT NOTICE

July 2012

TO: SAN FRANCISCO ELECTRICAL WORKERS ACTIVE/EARLY RETIREE PLAN PARTICIPANTS

FROM: PLAN OFFICE

RE: OPEN ENROLLMENT- Plan selection for 8/1/2012 – 7/31/2013

The Open Enrollment is being held during the month of July for coverage effective August 1, 2012. **Depending on where you reside,** you may choose from the following medical plans:

- **SELF FUNDED PPO**
- **KAISER HMO**
- **BLUE SHIELD HMO**

A comparison of the more significant benefits offered by these Plans is enclosed for your information. 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. Except under special circumstances, you may only add dependents who are not already enrolled, (including adult children who are between ages 19 and 26), during the open enrollment period.

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 27, 2012. If you wish to add a dependent, please contact the Fund Office.

Forms are also enclosed for your convenience if there has been a change in dependent status or you wish to change your beneficiary designation.

If you have any questions concerning this information or require additional information, do not hesitate to contact the Plan Office at (415) 263-3670.

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720 Market Street, Suite 700, San Francisco, CA 94102
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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.)

- ☐ 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)

If you 1) have had a change in dependent status or wish to add an eligible dependent not currently enrolled in the Plan, or 2) wish to change your beneficiary designation, please check the applicable box below and the Plan Office will see that you receive the appropriate form:

- ☐ CHANGE IN BENEFICIARY STATUS
- ☐ CHANGE IN DEPENDENT STATUS

_____
Your Name (please print)

_____
Signature

_____
Social Security Number

_____
Street Address

_____
City, State, Zip Code

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN
2012-2013 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	$1,250,000 effective 1/1/2012; $2,000,000 effective 1/1/2013; 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 & 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**	$20 per procedure	$50 per surgery
PREVENTIVE HEALTH CARE	In Network: No Charge; Includes all preventive services mandated under the Affordable Care Act. See Benefits For Out of Network Providers Described under **Benefits/Out-Of Pocket Maximum.** Benefits are limited to Annual Physical- up to $300 maximum; Mammograms, Pap Smears & Pelvic Exams, Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy, Prostate Cancer Screening	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 InformedRx effective 8/1/12. 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.	$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 CARE AND OUT OF AREA SERVICE *(Outside of Plan facilities)*	Worldwide Coverage. 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**	$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.

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.