

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE TRUST

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

2011-2012 OPEN ENROLLMENT NOTICE

July 2011

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

FROM: PLAN OFFICE

RE: OPEN ENROLLMENT- Plan selection for 8/1/2011 – 7/31/2012

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

- ♦ **SELF FUNDED PPO (see note below on grandfathered status)**
- ♦ **KAISER 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.

If you wish to remain under your present coverage, no action is required.

If you are changing coverage, complete the enclosed Request Form and return it to the Plan Office immediately. ALL CHANGE APPLICATIONS MUST BE RECEIVED NO LATER THAN July 29, 2011.

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.

The Self Funded PPO Plan is a "grandfathered health plan" under the ACA. As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Although being a grandfathered health plan means that the Plan is not required to include certain consumer protections of the ACA that apply to other plans (for example, the requirement for the provision of preventive health services without any cost sharing), the Plan must comply with certain other consumer protections in the ACA (for example the elimination of lifetime limits on benefits and extension of dependent coverage to adult children to age 26). In addition, the Plan provides health coverage benefits far beyond the "basic" level of benefits and has long maintained many consumer protections now required under the ACA (for example, it provides many preventive screening procedures at 100%, bans rescissions of coverage due to a member's health condition, exclusions for pre-existing conditions for children and adults, and "waiting periods" after a member attains initial coverage based on hours of work). Questions regarding which protections apply and which do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the contract plan administrator, EISB, at (415) 263-3670. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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720 Market Street, Suite 700, San Francisco, CA 94102
(415) 263-3670

PLAN and DEPENDENT CHANGE REQUEST FORM

I have read the enclosed Comparison of Benefits and would like to change to the following Plan. (Please check the appropriate box, fill in the information requested below and return this form and the information, along with the appropriate enrollment form and/or identification card, will be sent to you.)

- 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:

- 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
2011-2012 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.
PLAN MAXIMUMS	\$750,000 per calendar year per family member.	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 \$100 per person/\$200 family. All covered benefits paid at 100% of the PPO Contract rate after incurring \$1,500 per person in "out of pocket" covered expenses in a calendar year. Out of Network Providers: All benefits paid at 60% of usual and customary charges after satisfying deductible of \$100 per person/\$200 family. All covered benefits paid at 80% of usual and customary charges after incurring \$1,500 per person in "out of pocket" covered expenses in a calendar year.	Maximum Out of Pocket: \$1,500 Individual \$3,000 Family See Copay information under categories listed below.	Maximum out of Pocket: \$2,000 individual \$4,000 two-party \$6,000 family See Copay 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 Copay
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
PREVENTATIVE HEALTH CARE <i>(Routine check-ups, well baby care, immunizations, pap smears ,cancer screenings etc.)</i>	See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums for: Annual Physical- up to \$300 maximum; Preventative care and immunizations Pays 100% for Mammograms, Pap Smears & Pelvic Exams, Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy, Prostate Cancer Screening	No Charge	No Charge
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 Copay 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; Effective 8/1/2011: Coverage no longer insured through Optum Health (formerly PacifiCare Behavioral Health). Coverage now available directly through the Self Funded PPO Plan.	<u>Outpatient:</u> \$20 co-pay for Individual Visits \$10 co-pay for Group Visits <u>Inpatient:</u> Hospital covered in full	\$0 Copay per out patient treatment \$0 Copay per in patient confinement Effective 8/1/2011: Coverage no longer insured through Optum Health (formerly PacifiCare Behavioral Health). Coverage now available directly through the Blue Shield HMO Plan.
SUBSTANCE ABUSE TREATMENT <i>(Alcohol and Drug dependency)</i>	In Network: 100% of Contract Rate. See Benefits for Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums. Effective 8/1/2011: Coverage no longer insured through Optum Health (formerly PacifiCare Behavioral Health). Coverage now available directly through the Self Funded PPO Plan.	No Charge for inpatient Detox. \$20 Outpatient Visits. \$5 Outpatient Group Visits.	\$0 Copay per out patient treatment \$0 Copay per in patient confinement; Effective 8/1/2011: Coverage no longer insured through Optum Health (formerly PacifiCare Behavioral Health). Coverage now available directly through the Blue Shield HMO Plan.
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 CVS/Caremark. Individual responsible for 20% co-payment (maximum co-pay for generics of \$7 retail and \$17.50 mail order) payable to pharmacy at time prescription is filled.	\$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 <i>(Outside of Plan facilities)</i>	Coverage applies worldwide. Charges for certain emergency related treatment is covered under the \$5,000 in full in-patient Hospital benefit described above	\$50 Co-pay. Worldwide coverage for urgent or emergency services. Follow-up and routine care covered at Kaiser facility. Waived if admitted directly to hospital.	\$50 copay, waived if admitted to hospital. 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	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.

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ANNUAL NOTICE

[This information is included in your Summary Plan Description]

Women's Health and Cancer Rights Act of 1998

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

Newborn's and Mother's Health Protection Act

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

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