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

ANNOUNCEMENT TO ALL PLAN PARTICIPANTS

ENCLOSED IS YOUR OPEN ENROLLMENT MATERIAL FOR 2015. ENROLLMENT CHANGES ARE ACCEPTED IN JULY AND TAKE EFFECT AUGUST 1, 2015

The Trustees met on May 1, 2015, and approved increases to provider renewals **with no changes in benefits**. As of the Plan Year ended January 31, 2015, the Plan's uncommitted reserves were $21.2 million, representing an equivalent of 7.1 months of benefits and operating expenses, compared to uncommitted reserves of $17.33 million equivalent to 5.7 months of benefits and operating expenses for the Plan Year ended January 31, 2014. The $3.9 million increase in net assets as of the year end was due to a combination of factors including 1) an 8.2% increase in reported hours and 2) a $0.25 per hour increase to the employer contribution rate effective June 1, 2014.

With the $0.25 per hour increase to the contribution rate that took effect June 1, 2015, it is projected that the Plan's uncommitted reserves are sufficient to cover Plan expenses through the current Plan Year, assuming no significant decline in reported hours and modest investment returns. The Board of Trustees continue to monitor the Plan and are prepared to take action, as necessary, to ensure that the Plan remains healthy.

Clarification of Emergency Treatment (PPO Plan)

The Trustees adopted the attached changes to Sections 8.5(c) and (d) of the 2015 Summary Plan Description to conform the Plan's coverage for out-of-network emergency services, when treatment is required because of a serious threat to the health of the member or dependent (or unborn child), to the maximum limits allowed under the Affordable Care Act. Essentially the Plan cannot impose additional penalties or require pre-authorizations for such treatment.

New COBRA Rates

The Plan's COBRA rate is the lesser of 1) the calculated rate based on the applicable premiums plus a 2% administrative charge, and 2) the hourly employer Plan contribution rate, multiplied by the number of hours required for one month of Plan coverage. The following table, reflects the Active Plan COBRA rates that will apply for coverage beginning August 1, 2015 and ending July 31, 2016:

Plan	Medical Only	Medical, Dental & Vision
Self Funded PPO Plan	$1,590.00	$1,748.82
Kaiser Plan	$1,108.33	$1,267.16
Blue Shield HMO	$1,590.00	$1,748.82

If you have any questions regarding the change in benefits described above, please contact EISB at (415) 263-3670.

8.5 Limits on Covered Charges

(a) *Deductible.* The deductible is $150 per Covered Individual up to a maximum of $300 per family for each calendar year. This is the out-of-pocket expense for which you are responsible. Charges that are not Covered Charges and charges you pay as a coinsurance may not be used to satisfy the deductible amount. The deductible amount is subtracted from your Covered Charges and the remaining amount is multiplied by the coinsurance percentage to determine your amount payable. If charges in the last three months of a calendar year are applied toward the deductible, these charges will also be applied toward the deductible for the next calendar year. After the family deductible has been satisfied in a calendar year, no further deductible is required of that family unit for charges incurred in the remainder of that calendar year.

(b) *Coinsurance.* Except as provided otherwise in this section, after the deductible described in subsection (a) has been satisfied, Covered Charges will be paid at 80% of the contracted rate (100% for mental health and substance abuse charges) incurred in a calendar year performed by a Preferred Provider or at a Preferred Provider facility (*i.e.,* an "in-network" provider or facility), and at 60% of Reasonable and Customary charges if not performed by a Preferred Provider or at a Preferred Provider facility (*i.e.,* an "out-of-network" provider or facility), including for mental health and substance abuse charges. The 20% (or 40%) balance is your coinsurance, and is an out-of-pocket expense for which you are responsible. Once you or your Dependent have accumulated the maximum out-of-pocket Covered Charges described in subsection (d), the Plan will pay the balance of Covered Charges incurred during the remainder of the calendar year, up to the limit stated in subsection (d), at 100% for services performed in-network and at 80% for services performed out-of-network. Your Covered Charges are paid only to the extent provided in this section, so you should use in-network Physicians and Hospitals if you wish to minimize your out-of-pocket cost.

(c) *Out-Patient Hospital Benefits.* The Plan will pay the first $5,000 of out-patient Hospital Covered Charges in a calendar year at 100% when a Covered Individual:

(1) receives emergency out-patient treatment at a Hospital within 24 hours from the occurrence of an accident;

(2) receives emergency out-patient treatment for a condition characterized by acute symptoms that are of sufficient severity to cause a reasonable expectation, in the absence of immediate medical attention, that the health of the individual is in serious jeopardy; or

(3) requires Hospital facilities as an out-patient for a surgical operation.

~~If emergency care is needed in a facility that is out-of-network, payment will be based on the Hospital's billed Reasonable and Customary charges at the in-network coinsurance level. However, the first $5,000 in out-patient Covered Hospital Charges for non-emergency treatment or surgery performed at an out-of-network facility will be reimbursed at 80%. Covered Charges described in this subsection that exceed the $5,000 limit are subject to the rules in subsections (a) and (b).~~

(d) *Maximum Annual Out-of-Pocket Limit.* A Covered Individual shall not be required to pay in-network Covered Charges exceeding $1,500 per calendar year. Once a Covered Individual has paid $1,500 of out-of-pocket in-network Covered Charges in a calendar year, the Plan will pay the balance of Covered Charges incurred during the remainder of the calendar year at 100% for in-network services and at 80% for out-of-network services. In no event will the in-network out-of-pocket Covered Charges exceed the maximum amount allowable under the Affordable Care Act, which for 2015 is $13,200 per family ($6,600 single).

Special Rules for Out-of-Network Emergency Care. If you experience a medical condition with acute symptoms (including severe pain) such that you require emergency care to address a serious threat to your (or your unborn child's) health and/or the functioning of an organ or other part of your body, you may seek emergency care without prior authorization and without regard to whether the emergency care provider (*e.g.*, a hospital) is in-network or out-of-network. The Plan will cover the charges of an out-of-network emergency care provider at least to the extent of the greatest of (i) what the Plan negotiated for the services with in-network providers (excluding any in-network co-payment or co-insurance imposed on the Participant or Dependent), (ii) the provider's Reasonable and Customary Charges minus any co-pays and co-insurance that would have applied to an in-network provider, and (iii) the amount that would be paid by Medicare minus any co-pays and co-insurance that would have applied to an in-network provider. The preceding sentence will be applied in accordance with 45 C.F.R. §147.138(b).