

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN

**720 MARKET ST., STE. 700
SAN FRANCISCO, CA 94102**

Phone (415) 263-3670 Fax (415) 263-3672

SECTION 1: PARTICIPANT ENROLLMENT INFORMATION

| | | | | |
|---|--|----------------------------------|--|--|
| Check One: <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> 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 | <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Registered Dom. Partner | Gender |
| | | | | <input type="checkbox"/> Female <input type="checkbox"/> Male |
| Plan Selection* | <input type="checkbox"/> Self Funded PPO | | <input type="checkbox"/> Kaiser | <input type="checkbox"/> 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 HMO 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 You 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unemployed | | | | |
| If yes, did your spouse elect to be covered under her employer's plan? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| If yes, provide information below. | | | | |
| Name of Insurance | | Effective Date | | |
| Address | | | | Phone |
| Does your Spouse/Partner's insurance provide coverage for dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| If Yes, is coverage provided for Adult Child(ren) listed in Section 4? <input type="checkbox"/> Yes <input type="checkbox"/> 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 |

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN

720 MARKET ST., STE. 700

SAN FRANCISCO, CA 94102

Phone (415) 263-3670 Fax (415) 263-3672

An Adult Child age 19 through age 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 RETIREE HEALTH & WELFARE
PLAN 2018-2019 COMPREHENSIVE MEDICAL BENEFITS SUMMARY**

| PRINCIPAL FEATURES | SELF FUNDED PPO PLAN |
|---|---|
| CHOICE OF PROVIDERS | Choose any physician. Choose a PPO Physician/Hospital to receive maximum benefits. |
| PLAN MAXIMUMS (Per Calendar Year Per Family Member) | No annual maximum effective 1/1/2014 |
| BENEFITS/OUT OF POCKET MAXIMUMS | <u>In Network Providers:</u> 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. <u>Out of Network Providers:</u> 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. |
| HOSPITAL CONFINEMENT <i>(Room and board, surgery, anesthesia and miscellaneous)</i> | See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums |
| DOCTOR VISITS – Office/Hospital | See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums |
| OUTPATIENT LAB & X-RAYS | See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums |
| 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 |
| PREVENTIVE TREATMENT SERVICES FOR ADULTS, WOMEN, AND CHILDREN | 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. |
| EMPLOYEE ASSISTANCE PROGRAM (EAP) | Life Referrals (800) 985-2405; 3 Complimentary counseling sessions; Parenting/Childcare; Legal Advice; Financial Advice, Eldercare, etc. |
| AMBULANCE SERVICES | See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums ; payable if required to move patient from place of injury or illness to nearest hospital equipped to provide necessary care. |
| MATERNITY CARE Mother/Newborn Hospital Expenses Newborn Care | (Members and Spouses/Domestic Partners only) See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums Same as hospital confinement coverage shown above, for 48 hours following normal vaginal delivery and 96 hours following delivery by caesarian section. Well Baby covered while mother is confined |
| EYE EXAMINATIONS/GLASSES | Covered through Vision Service Plan; \$10 co-payment; examination and lenses available every 12 months; new frames available every 24 months. |
| MENTAL HEALTH /SUBSTANCE ABUSE TREATMENT | In Network: 100% of the PPO Contract Rate; See Benefits for Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums . |
| PHYSICAL THERAPY | See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums ; Services subject to medical review for determination of medical necessity and appropriate treatment frequency. |
| PRESCRIPTION DRUGS | Administered through Catamaran. 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. 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. |
| PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT | See Benefits for In and Out of Network Treatment Described under Benefits/Out-Of Pocket Maximums ; Rental of durable medical equipment, not to exceed the purchase price |
| EMERGENCY CARE AND OUT OF SERVICE AREA <i>(Outside of Plan facilities)</i> | 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] |
| DENTAL COVERAGE | This is a self-funded dental program administered by Delta Dental. Separate brochure/summary is available. |
| SPECIAL NOTES Your eligible dependents are: - Lawful Spouse, Registered Domestic Partner, Natural/Step/ Adopted Children, Children of Registered Domestic Partner 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 PPO Plan payments are based on allowable charges. Blood donations for your own surgery covered if physician recommends. |
| MEDICARE ELIGIBLE RETIREES AND DEPENDENTS | |
| The Plan will offset covered charges by the amount payable by Medicare, even if a Medicare eligible retiree or dependent fails to enroll or is treated by a non-Medicare certified provider. | |

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 RETIREE HEALTH & WELFARE PLAN
2018-2019 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 <i>Room and board, surgery, anesthesia and miscellaneous</i> | 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 <i>(All preventive screenings mandated by the Affordable Care Act).</i> | 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 |

OVER

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