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

2016-2017 OPEN ENROLLMENT NOTICE

June 2016

TO: SAN FRANCISCO ELECTRICAL WORKERS RETIREE PLAN PARTICIPANTS

FROM: BOARD OF TRUSTEES

RE: OPEN ENROLLMENT- Plan selection for 8/1/2016– 7/31/2017

The Open Enrollment is being held during the month of July for coverage effective August 1, 2016. **Depending on where you reside,** you may choose from the following medical plans:

- **SELF FUNDED PPO**
- **KAISER or KAISER SENIOR ADVANTAGE HMO**
- **BLUE SHIELD HMO (non-Medicare eligible retirees only)**

A comparison of the more significant benefits along with the Summary of Benefits Coverage for each medical plan as required by the Affordable Care Act and the current monthly co-payment schedule are enclosed. 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 25, 2016.

REMINDER: All Members who are eligible for Medicare must sign up for both Parts A (Hospital) and B (other medical) of Medicare. If you are in the Self Funded PPO Plan, your claims will be processed as though you are covered by Medicare even if you fail to sign up or you are treated by a non-Medicare certified provider. Medicare eligible retirees or dependents who elect Kaiser but do not enroll in Kaiser Senior Advantage will be charged the difference between the premium for the Senior Advantage Plan and the amount charged to the Trust.

Continued on Other Side

Medicare-eligible Retirees are reminded not to enroll in a separate Medicare Part D prescription program outside of the plan. The prescription drug benefit you currently receive under the Plan (whether PPO Plan or Kaiser Senior Advantage) provides better coverage, at less cost to you, than other Medicare Part D programs. The Centers for Medicare Services allows enrollment in one Medicare Part D Plan only. If you enroll in Medicare Part D outside of the Plan, you and your dependents will immediately lose all major medical coverage under the Plan and you will not be eligible to re-enroll until the next open enrollment period following termination of your Medicare Part D coverage.

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

SAN FRANCISCO ELECTRICAL WORKERS RETIREE HEALTH & WELFARE PLAN
2016-2017 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 *Room and board, surgery, anesthesia and miscellaneous*	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 *(All preventive screenings mandated by the Affordable Care Act).*	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

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

SAN FRANCISCO ELECTRICAL WORKERS RETIREE HEALTH & WELFARE PLAN
2016-2017 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	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.
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**
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 (*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]
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.

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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.)

Non-Medicare Retirees

- ☐ SELF-FUNDED PPO (AVAILABLE WORLD WIDE)
- ☐ KAISER (Limited to certain geographic areas in California Only - contact Plan Office for more information)
- ☐ 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).

Medicare Retirees

- ☐ SELF-FUNDED PPO (AVAILABLE WORLD WIDE)
- ☐ KAISER SENIOR ADVANTAGE (Limited to certain geographic areas in California Only - contact Plan Office for more information)

If you have had a change in dependent status or wish to add an eligible dependent not currently enrolled in the Plan, please check the applicable box below and Plan Office will send you a Beneficiary Form:

- ☐ CHANGE IN DEPENDENT STATUS

_____
Your Name (please print)

_____
Signature

_____
Social Security Number

_____
Street Address

_____
City, State, Zip Code

[Attached is a schedule showing the monthly co-payment rates for February 1, 2016 through January 31, 2017.]

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN

MONTHLY COVERAGE PAYMENT SCHEDULE EFFECT 2/1/2016

TABLE 1: EARLY RETIREE (AGE 55 TO 62)	
Plan	*Monthly Payment*
Kaiser Family	**$1,766.00**
Blue Shield (HMO) Family	**$1,975.00**
Self Funded Plan (PPO)	**$2,187.00**

TABLE 2: EARLY RETIREE (AGE 62 TO 65)*	
Plan	*Monthly Payment*
Kaiser-Single	**$706.00**
Kaiser-Family	**$1,060.00**
Blue Shield (HMO)-Single	**$790.00**
Blue Shield (HMO)-Family	**$1,185.00**
Self Funded Plan (PPO)-Single	**$875.00**
Self Funded Plan (PPO)-Family	**$1,312.00**

*Participants Who Did Not Meet the Service Requirements for Regular Retiree Status Immediately Preceding Age 62

TABLE 3: EARLY RETIREE (AGE 62 TO 65)**	
Plan	*Monthly Payment*
Kaiser	**$605.00**
Blue Shield (HMO)	**$605.00**
Self Funded Plan (PPO)	**$605.00**

**Participants Who Met the Service Requirements for Regular Retiree Status Immediately Preceding Age 62

TABLE 4: OTHER RETIREE CATEGORIES		
All Plans	*Monthly Payment*	
Surviving Spouses and Under Age 65 Disabled Retirees	**$525.00**	
Over Age 65 retirees who attained, or will attain, age 75 on or after 1/1/2007	**Single**	**$230.00**
	Family	**$460.00**
Retirees who attained Age 75 before 1/1/2007	**$0.00**	