San Mateo County Electrical Construction Industry
Health & Welfare Plan
IBEW Local 617

Retirement Workshop
March 19, 2022
Zoom Webinar

www.ibew617benefits.com

SAN MATEO ELECTRICAL WORKERS

RETIREE HEALTH & WELFARE PLAN

March 19, 2022

RULES TO QUALIFY:

1) Must be at least 55 years old.

2) Must have CURRENT eligibility at the time of retirement.

3) Must have been eligible under the San Mateo Electrical Workers Health Care Benefits Plan, (or another IBEW Local as long as proof of eligibility is provided) for 10 out of the last 15 years “AND” 2 of the last 5 years immediately preceding date of retirement.

4) Currently receiving (or have recently applied for) Pension benefits from San Mateo County Electrical Construction Industry Retirement Trust (IBEW Local 617), or another IBEW Local as long as proof of Pension contributions are provided.

5) If eligible for Medicare, must have Medicare Parts A and B.

6) The medical insurance that you have at time of Retirement is what you will remain on until the next annual Open Enrollment which is in June of each year.

INSURANCE BENEFITS ON THE RETIREE PLAN:

For Early Retirees, the two options are the Self-Funded PPO Plan and Kaiser. Please note that the Self-Funded benefits are slightly different than the Active Plan. (See attached Summary of Benefits) The Kaiser benefits are the same as the Kaiser Active Plan. The Pharmacy benefit for the PPO Plan has a $100 deductible and the Dental and Vision Benefits remain the same. Once retired, there is **no longer** a Life Insurance benefit.

Once a retiree has Medicare, the two options available are: Blue Shield and Kaiser Senior Advantage. (See attached Summary of Benefits)

Since you will be enrolled in the group pharmacy benefit, you will not need additional pharmacy coverage. Again, the Dental and Vision benefits will remain the same, but there is no Life Insurance benefit.

The retiree billing statements are sent out every quarter. It is up to the retiree whether they want to pay a quarter at a time, or pay it monthly.

Please note, that the payments are due by the 25th of the month prior to the month of coverage; for example: Payment for March 2022 coverage is due no later than February 25, 2022. You also have the option to set up automatic payments (bill pay) through your bank.

If you plan on moving out of California prior to age 65, you will not be eligible for the Blue Shield Medicare Supplement Plan or Kaiser Senior Advantage when you become 65 years old and are eligible for Medicare. Your only option will be to enroll in The Hartford Medicare supplement plan. If you choose The Hartford Medicare supplement plan, you will also be enrolled in the SavRx Prescription plan. If you enroll in The Hartford Plan, you will also continue coverage for dental and vision. See attached benefit summary.

RETURNING TO WORK ONCE RETIRED:

Once a participant retires, and he returns to work either part time or full time, he will remain in the retiree Health & Welfare Plan. If the retiree works up to 40 hours or less during a calendar month, the Employer contributions made on his or her behalf for the hours worked will be used to offset the required retiree premium, with any remainder to be paid by the participant. If the hours reported for such a Participant (who had previously retired) exceed the hour requirement for retired Participants per calendar month (more than 40 hours), the excess Employer contributions made on the Participants behalf shall be retained by the Plan.

CONVERTING RESERVE HOURS TO RETIREE RESERVE BANK:

See attached examples.

RETIREE HEALTH & WELFARE RATES:

See attached.

NAVIA – Health Reimbursement Claim Form

See attached

SHORT TERM DISABILITY:

See attached.

PLEASE NOTE:

Early Retirees, (under the age of 65) MUST continue to pay the I.O. Dues to the union in order to remain a member in good standing. Please contact the Local 617 Union Office for more details.

Also attached to this packet is information on the I.O. Dues Retirement Fund.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibew617benefits.com or call the Trust Fund Office (408) 288-4400 or toll-free (877) 827-4239. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.https://www.healthcare.gov/sbc-glossary or call 1-408-288-4400 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** for network providers **$250**/Individual or **$500**/family for out-of-network providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**Yes. $100** for retail prescription drug expenses.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**Yes**. For network providers., **$1,500** person/**$3,000** family. For out-of-network providers, **$4,500** person/**$9,000** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	**Yes.** See www.anthem.com/ca/ or call 1-408-288-4400 or Anthem Blue Cross at 1-800-688-3828 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's Level One network. You will pay the most if you use Level Two out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Level One Network Provider (You will pay the least)	Level Two Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit; deductible does not apply. No Charge COVID-19 test (during public health emergency period)	$15 copay/visit. No Charge COVID-19 test (during public health emergency period). 20% coinsurance COVID-19 treatment.	None. Effective during public health emergency, COVID-19 visits for testing covered at no cost for both in-network & non-network. COVID-19 Treatment is covered at no cost (Network provider) but 20% coinsurance after deductible (Non-Network).
	Specialist visit	$15 copay/visit; 20% coinsurance for chiropractor & acupuncture	$15 copay/visit; 40% coinsurance; after deductible for chiropractor & acupuncture	20 visits/year (chiropractor & acupuncture).
	Preventive care/screening/ immunization	No Charge. Deductible does not apply.	40% coinsurance; after deductible. No Charge COVID-19 Vaccination.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Well baby care & immunizations covered from birth to age 3. No Prior Auth. for COVID-19 vaccination and covered at no charge at Network, Non-Network and participating Sav RX pharmacy facilities.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance; after deductible	None. Effective during public health emergency, COVID-19 testing and screening is covered at no cost per federal guidance.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance; after deductible	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.savRx.com or call toll free 1-866-233-4239.	Generic drugs	$5 copay retail); $10 copay (mail)	100% less reimbursement to network pharmacy	Covers up to 34-day supply and must meet $100 calendar year deductible (retail subscription); up to 90-day supply (mail order prescription).
	Preferred brand drugs	$15 copay retail); $30 copay (mail)	100% less reimbursement to network pharmacy	
	Non-preferred brand drugs	$25 copay retail); $50 copay (mail)	100% less reimbursement to network pharmacy	
	Specialty drugs	20% coinsurance (if supplied by doctor/hospital); Same as Generic & Non-Preferred Brand copays if supplied by retail/mail order pharmacy	40% coinsurance after deductible (if supplied by doctor/hospital); Same as Generic & Non-Preferred Brand copays if supplied by retail/mail order pharmacy	Covers up to 90-day supply (retail subscription or mail order prescription). Preauthorization required.
If you have outpatient	Facility fee (e.g., ambulatory	20% coinsurance	40% coinsurance; after	None.

[* For more information about limitations and exceptions, see the plan or policy document at http://ibew617benefits.com/#..]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Level One Network Provider (You will pay the least)	Level Two Out-of-Network Provider (You will pay the most)	
surgery	surgery center)		deductible	
	Physician/surgeon fees	20% coinsurance	40% coinsurance; after deductible	None.
If you need immediate medical attention	Emergency room care	20% coinsurance after $50 copay, waived if admitted	40% coinsurance; after $50 deductible, waived if admitted. 20% coinsurance COVID-19 treatment.	Emergency room treatment not considered an emergency subject to $50 copay but copay waived if admitted. Effective during public health emergency, COVID-19 treatment is covered at no cost (Network provider) but 20% coinsurance after deductible waived if admitted (Non-Network).
	Emergency medical transportation	20% coinsurance	40% coinsurance; after deductible	See of Article VI, Section J.14 of Plan Document for limitations.
	Urgent care	20% coinsurance	40% coinsurance; after deductible	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance; after deductible. 20% coinsurance COVID-19 treatment.	Preauthorization required for non-emergency hospital admissions. Effective during public health emergency, COVID-19 treatment is covered at no cost (Network provider) but 20% coinsurance after deductible (Non-Network).
	Physician/surgeon fees	20% coinsurance	40% coinsurance; after deductible	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance; after deductible	For Substance abuse services, preauthorization required through Beat It! Optum is the primary provider for Behavioral Health/Mental Health Services. The Plan also has an Employee Assistance Program through Optum.
	Inpatient services	20% coinsurance	40% coinsurance; after deductible	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance; after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance; after deductible	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance; after deductible	
If you need help recovering or have other special health	Home health care	20% coinsurance	40% coinsurance; after deductible	20 visits/year (Out-of-network care).
	Rehabilitation services	20% coinsurance	40% coinsurance; after deductible	20 visits/year. See Section J.6 of Plan Document for more information on limitations.

[* For more information about limitations and exceptions, see the plan or policy document at http://ibew617benefits.com/#..]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Level One Network Provider (You will pay the least)	Level Two Out-of-Network Provider (You will pay the most)	
needs	Habilitation services	20% coinsurance	40% coinsurance; after deductible	20 visits/year.
	Skilled nursing care	20% coinsurance	40% coinsurance; after deductible	Plan will only cover costs following discharge from acute care facility.
	Durable medical equipment	20% coinsurance	40% coinsurance; after deductible	See Article VI, Section J. 23 of Plan Document for more information on limitations.
	Hospice services	20% coinsurance	40% coinsurance; after deductible	See of Article VI, Section J.14 of Plan Document for limitations.
If your child needs dental or eye care	Children's eye exam (VSP)	$25 copay	Up to $50	Coverage limited to one exam/year.
	Children's glasses (VSP)	$25 copay and covered up to $120 plus 20% discount on out-of-pocket expenses (Frames)	See Article X of Plan Booklet for scheduled allowance.	Coverage limited to one pair of glasses/24 months and one set of lenses/year. Contact 1-408-288-4400 or 1-800-877-7195 or for VSP booklet.
	Children's dental check-up (Delta Dental)	No Charge	No Charge	Deductibles waived for diagnostic & preventive services. See Article IX of Plan Booklet.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric Surgery (unless medically necessary)
- Dental Care (Adult) except as permitted under Plan Document & Covered under Delta Dental
- Infertility Treatment
- Hearing Aids (limited to Active Employees)
- Non-emergency care when traveling outside U.S.
- Routine eye care (Adult) except as covered under VSP
- Routine foot care
- Weight Loss Program (except nutritional counseling)
- Holistic medicine
- Learning Disabilities

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to 20 visits/year).
- Cancer Clinical Trials (Subject to Plan limitations)
- Chiropractic Care (limited to 20 visits/year)
- Cosmetic Surgery (subject to Plan limitations)
- Long-term care
- Nutritional Counseling
- Orthodontic & Dental (through Delta Dental)
- Private Duty Nursing
- Sleep Apnea Screening/Assessment (limited to Participants, no Dependents)

[* For more information about limitations and exceptions, see the plan or policy document at http://ibew617benefits.com/#..]

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform . Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: **United Administrative Service** at 1-408-288-4400 or 1-877-827-4239 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-408-288-4400 or 1-877-827-4239.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-408-288-4400 or 1-877-827-4239.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at http://ibew617benefits.com/#..]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$15
Coinsurance	20%
What isn't covered	
Limits or exclusions	N/A
The total Peg would pay is	**$2572.0**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	20%
What isn't covered	
Limits or exclusions	N/A
The total Joe would pay is	**$**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$50
Coinsurance	20%
What isn't covered	
Limits or exclusions	N/A
The total Mia would pay is	**$420.00**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Principal Benefits for Kaiser Permanente Traditional HMO Plan (6/1/21—5/31/22)

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Contact Center.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$15 per visit
Most Physician Specialist Visits	$15 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$15 per visit
Most physical, occupational, and speech therapy	$15 per visit

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Allergy antigens (including administration)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$100 per admission

Emergency Health Coverage	You Pay
Emergency Department visits	$50 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share)

Ambulance Services	You Pay
Ambulance Services	$50 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most specialty items at a Plan Pharmacy	$10 for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	20% Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$100 per admission
Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$100 per admission
Individual outpatient substance use disorder evaluation and treatment	$15 per visit
Group outpatient substance use disorder treatment	$5 per visit

Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge

(continues)

Benefit Summary *(continued)*

Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of $175 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	the Cost Share you would pay if the Services were to treat any other condition
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

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Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (6/1/21—5/31/22)

Plan Out-of-Pocket Maximum	
For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount:	
For any one Member	$1,500 per calendar year
Plan Deductible	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$10 per visit
Most Physician Specialist Visits	$10 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	$10 per visit
Urgent care consultations, evaluations, and treatment	$10 per visit
Physical, occupational, and speech therapy	$10 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$10 per visit
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$100 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$35 per visit
Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share)	
Transportation Services	**You Pay**
Ambulance Services	$50 per trip
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines	$10 for up to a 100-day supply
Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$100 per admission
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	$100 per admission
Individual outpatient substance use disorder evaluation and treatment	$10 per visit

(continues)

Substance Use Disorder Treatment	You Pay
Group outpatient substance use disorder treatment	$5 per visit

Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge

Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of $175 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	No charge
Ostomy and urological supplies	No charge
Meals delivered to your home following discharge from a hospital due to congestive heart failure	No charge up to two meals per day in a consecutive four-week period, once per calendar year

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For additional information, please refer to the *Summary of Benefits* booklet enclosed; for a complete explanation, refer to the *EOC*.

YOUR KAISER PERMANENTE

CHIROPRACTIC BENEFIT

Kaiser Foundation Health Plan, Inc., contracts with American Specialty Health Plans of California, Inc. (ASH Plans), to make the ASH Plans network of Participating Chiropractors available to you. When you need chiropractic care, you have direct access to more than 3,100 licensed chiropractors in California. Just follow these simple steps:

1. Find an ASH Plans Participating Chiropractor near you.
   - Online at **ashcompanies.com/kp**
   - Or call **1-800-678-9133** (TTY users call **711**), weekdays from 5 a.m. to 6 p.m. (Pacific time)
2. Schedule an appointment.
3. Pay for your office visit when you arrive for your appointment.

Services	Cost Sharing and Office Visit Maximums
Chiropractic Services are covered when a Participating Chiropractor finds that the services are medically necessary to treat or diagnose Neuromusculoskeletal Disorders. You can obtain services from any ASH Plans Participating Chiropractor without a referral from a Plan physician.	**Office visit cost share:** $15 copay per visit Office visit limit: 40 visits per year Chiropractic appliance benefit: If the amount of the appliance in the ASH Plans fee schedule exceeds $50, you will pay the amount in excess of $50, and that payment will not apply toward any applicable deductible or out-of-pocket maximum. Covered chiropractic appliances are limited to: elbow supports, back supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units, ankle braces, knee braces, rib supports, and wrist braces.

Office visits: Each office visit counts toward the calendar year visit limit even if an adjustment is not provided during the visit.

X-rays and laboratory tests: Medically necessary X-rays and laboratory tests are covered at no charge when prescribed as part of covered chiropractic care when a Participating Chiropractor provides the Services or refers you to a Participating Provider for the Services.

Participating Chiropractors

ASH Plans contracts with Participating Chiropractors and other Participating Providers to provide covered Chiropractic Services, including laboratory tests, X-rays, and chiropractic appliances. You must receive covered services from a Participating Provider, except for Emergency Chiropractic Services, Urgent Chiropractic Services, and services that are not available from Participating Providers that are authorized in advance by ASH Plans. The list of Participating Chiropractors is available on the ASH Plans website at **ashcompanies.com/kp** or by calling the ASH Plans Member Services Department toll free at **1-800-678-9133** (TTY users call **711**), weekdays from 5 a.m. to 6 p.m. The list of Participating Chiropractors is subject to change at any time without notice.

How to obtain services: To obtain covered services, call a Participating Chiropractor to schedule an initial examination. If additional services are required, verification that the Services are Medically Necessary may be required. An ASH Plans clinician in the same or similar specialty as the provider of Chiropractic Services under review will decide whether the Chiropractic Services are Medically Necessary Services. ASH Plans will disclose to you, upon request, the process that it uses to authorize a Treatment Plan. For more information about how to obtain covered Chiropractic Services, please refer to the *Chiropractic Services Amendment* of your Health Plan *Evidence of Coverage*.

Emergency and Urgent Chiropractic Services

Covered Emergency Chiropractic Services are provided for the treatment of a sudden and unexpected onset of a Neuromusculoskeletal Disorder, nausea, or pain, which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person could expect the absence of immediate Chiropractic Services to result in serious jeopardy to your health or body functions or organs. Covered Urgent Chiropractic Services consist of Chiropractic Services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the Service Area. We cover Emergency Chiropractic Services and Urgent Chiropractic Services provided by both Participating Chiropractors and Non–Participating Chiropractors. We do not cover follow-up or continuing care from a Non–Participating Chiropractor unless ASH Plans has authorized the services in advance. Also, we do not cover services from a Non–Participating Chiropractor that ASH Plans determines are not Emergency Chiropractic Services or Urgent Chiropractic Services.

Second Opinions

You may request a second opinion in regard to covered Services by contacting another Participating Chiropractor. A Participating Chiropractor may also request a second opinion in regard to covered Services by referring you to another Participating Chiropractor in the same or similar specialty.

Your Costs

When you receive covered services, you must pay your Cost Share amount as described in the *Chiropractic Services Amendment* of your Health Plan *Evidence of Coverage*. The Cost Share does not apply toward the out-of-pocket maximum described in the Health Plan *Evidence of Coverage*.

Getting Assistance

If you have a question or concern regarding the services you received from an ASH Plans Participating Provider, you may call ASH Plans Member Services toll free at **1-800-678-9133** (TTY users call **711**), weekdays from 5 a.m. to 6 p.m., or write ASH Plans at:

ASH Plans Member Services
P.O. Box 509002
San Diego, CA 92150-9002

Grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about services you received. You may submit your grievance orally or in writing to Kaiser Permanente, as described in your Health Plan *Evidence of Coverage*.

Exclusions and Limitations

- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational services
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other types of diagnostic imaging or radiology other than X-rays covered under the "Covered Services" section of your *Chiropractic Services Amendment*
- Ambulance and other transportation
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under the *Chiropractic Services Amendment*
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California except for Emergency Chiropractic Services and Urgent Chiropractic Services
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- For Chiropractic Services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- Maintenance care (services provided to members whose treatment records indicate that they have reached maximum therapeutic benefit)

Definitions

ASH Plans: American Specialty Health Plans of California, Inc., a California corporation.

Chiropractic Services: Services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic appliances) for the treatment of your Neuromusculoskeletal Disorder.

Neuromusculoskeletal Disorders: Conditions with associated signs and symptoms related to the nervous, muscular, or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders, or biomechanical dysfunction of the joints of the body or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related neurological manifestations or conditions.

Participating Chiropractor: A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you. A list of Participating Chiropractors is available on the ASH Plans website at **ashcompanies.com/kp**, or by calling the ASH Plans Member Services Department at **1-800-678-9133** (TTY users call **711**). The list of Participating Chiropractors is subject to change at any time, without notice. If you have questions, please call the ASH Plans Member Services Department.

Participating Provider: A Participating Chiropractor or any licensed provider with which ASH Plans contracts to provide covered care, including laboratory tests or X-rays that are covered chiropractic care.

Treatment Plan: A proposed course of treatment for your Neuromusculoskeletal Disorder, which may include laboratory tests, X-rays, chiropractic appliances, and a specific number of visits for chiropractic manipulations, adjustments, and therapies that are Medically Necessary Chiropractic Services for you.

This is only a summary of your chiropractic coverage, and is intended to highlight only the most frequently asked questions about the benefit, including cost shares. Please refer to the *Chiropractic Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for details about the terms and conditions of your chiropractic coverage, including exclusions and limitations, Emergency Chiropractic Services, and Urgent Chiropractic Services. To obtain the amendment to your *Evidence of Coverage*, please contact your group.

Some capitalized terms have special meaning in this document, as described in the "Definitions" section. Please also see the "Definitions" section of your *Chiropractic Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for terms you should know.

American Specialty Health.
Plans of California

PLAN G

PARTS A & B

* Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC GYM ACCESS THROUGH SILVERSNEAKERS® FITNESS PROGRAM			
	$0	100%	$0

PLAN G EXTRA

MEDICARE (PART A)
HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* – Semiprivate room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st through 90th day	All but $371 a day	$371 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare-eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* – You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G EXTRA

MEDICARE (PART B)
MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B excess charges (above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES			
	100%	$0	$0

PLAN G EXTRA

PARTS A & B

* Once you have been billed $203 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $203 of Medicare-approved amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC GYM ACCESS THROUGH SILVERSNEAKERS® FITNESS PROGRAM	$0	100%	$0
PHYSICIAN CONSULTATION BY PHONE OR VIDEO THROUGH TELADOC	$0	100%	$0 per consult
OVER-THE-COUNTER ITEMS THROUGH CVS – Eligible over-the-counter (OTC) items are available through the OTC Catalog, at **blueshieldca.com/medicareOTC.**	$0	Up to $100 one-time use per quarter allowance	All costs above $100 one-time use per quarter allowance

PLAN G EXTRA

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES – Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor.*			
Comprehensive eye exam once every 12 months	$0	**In-Network:** 100% after the $20 copayment **Out-Of-Network:** Up to $50 allowance	**In-Network:** $20 copay **Out-Of-Network:** All costs above the $50 allowance
Eyeglass frame once every 24 months	$0	**In-Network:** Up to $100 allowance **Out-Of-Network:** Up to $40 allowance	**In-Network:** All costs above the $100 allowance **Out-Of-Network:** All costs above $40 allowance

PLAN G EXTRA

Other benefits - not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES – Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor.*			
Eyeglass lenses once every 12 months • Single vision • Bifocal • Trifocal • Aphakic, lenticular monofocal, or multifocal	$0	**In-Network:** 100% after the $25 copayment **Out-Of-Network:** Single vision: Up to $43 allowance Bifocal: Up to $60 allowance Trifocal: Up to $75 allowance Aphakic or lenticular monofocal or multifocal: Up to $104 allowance	**In-Network:** $25 copay **Out-Of-Network:** All costs above the allowance

PLAN G EXTRA

Other benefits - not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
VISION SERVICES – Your vision benefits are provided by Vision Service Plan (VSP). This benefit offers one of the largest national networks of independent doctors located in retail, neighborhood, medical, and professional settings. You can lower any out-of-pocket costs by choosing network providers for covered services. Participating providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor.*			
Contact lenses (instead of eyeglass lenses) once every 12 months • Non-elective (medically necessary) – Hard or Soft – one pair • Elective (cosmetic/convenience) – Hard – one pair • Elective (cosmetic/convenience) – Soft – Up to a three- to six-month supply for each eye based on lenses selected	$0	**Non-elective In-Network:** Up to $500 allowance after the $25 copayment **Non-elective Out-Of-Network:** Non-elective (Hard or Soft): Up to $200 allowance **Elective In-Network:** Up to $120 allowance after the $25 copayment **Elective Out-Of-Network:** Up to $100 allowance	**Non-elective and Elective In-Network:** $25 copay **Non-elective and Elective Out-Of-Net-work:** All costs above the allowance

PLAN G EXTRA

Other benefits - not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HEARING AID SERVICES – Your hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. Participating providers may be located through a directory at **blueshieldca.com/medPlanExtras**. If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.			
Hearing aid examinations for the appropriate type of hearing aid (once every 12 months)	$0	100%	$0
Hearing aid services every 12 months include: • Hearing aid instrument • Choice of the private-labeled Basic (mid-level) or Reserve (premium-level) technology hearing aid models • Up to two hearing aids per 12 months in the following styles: – In the ear – In the canal – Completely-in canal – Behind-the-ear; or – Receiver-in-the-ear • All technology levels include: – One consultation – Two-year supply of batteries per hearing aid; and – Three-year extended warranty	$0	$0	**Basic Technology Level** $449 per hearing aid plus $50 per visit for optional in-person appoint-ments. **Reserve Technology Level** $699 per hearing aid

PLAN G EXTRA

Other benefits - not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HEARING AID SERVICES – Your hearing aid services benefits are provided by EPIC Hearing Healthcare (EPIC). This benefit is designed for you to use EPIC network providers. Participating providers may be located through a directory at **blueshieldca.com/medPlanExtras**. If you choose to use out-of-network providers, those services will not be covered. This benefit is separate from diagnostic hearing examinations and related charges as covered by Medicare.			
• Basic technology level hearing aids include: – One behind-the-ear hearing aid delivered directly to your home – Follow-up care provided by Epic online, telephonically, or by video chat for no additional fee; and – Follow-up care in-person appointments, which are subject to an additional fee per visit • Reserve technology level hearing aids include: – One hearing aid delivered in-person – Up to three follow-up visits in-person for hearing aid fitting, consultation, device check, and adjustment within the first year for no additional fee; and – Ear impressions and molds			**Basic Technology Level** $449 per hearing aid plus $50 per visit for optional in-person appointments. **Reserve Technology Level** $699 per hearing aid

GROUP BENEFITS

GROUP RETIREE INSURANCE PLAN
SUMMARY OF COVERAGE

PREMIUM CHOICE PLAN

UNDERWRITTEN BY: HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Calendar Year Deductible: $0 Lifetime Maximum: Unlimited

PART A SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
HOSPITALIZATION [2] Semi-private room and board, general nursing, and miscellaneous services and supplies:			
First 60 days	All but $1,288	100% of Medicare Part A Deductible	**$0**
61st through 90th day	All but $332 per day	100% of Medicare Part A Coinsurance	**$0**
91st through 150th day (60 day Lifetime Reserve Period)	All but $644 per day	100% of Medicare Part A Coinsurance	**$0**
Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime	$0	100%	**$0**
SKILLED NURSING FACILITY CARE Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies. You must meet Medicare's requirement which includes hospitalization of at least 3 days. You must enter a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	**$0**
21st through 100th day	All but $161 per day	Up to 100% of Medicare SNF Coinsurance	**$0**
101st through 365 day	$0	$0	**All other charges**

GROUP RETIREE INSURANCE PLAN
SUMMARY OF COVERAGE FOR PREMIUM CHOICE PLAN

THE HARTFORD

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
BLOOD DEDUCTIBLE – Hospital Confinement and Out-Patient Medical Expenses When furnished by a hospital or skilled nursing facility during a covered stay.			
First 3 pints Additional amounts	$0 100%	100% $0	**$0** **$0**
HOSPICE CARE Pain relief, symptom management and support services for terminally ill.			
As long as Physician certifies the need	All costs, but limited to costs for out-patient drug and in-patient respite care	Co-insurance charges for in-patient respite care, drugs and biologicals approved by Medicare	**All other charges**

PART B SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
OUT-PATIENT MEDICAL EXPENSES **The Policy may cover the following Medicare Part B Benefits:** • *Physician Services Benefit* • *Specialist Services Benefit* • *Outpatient Hospital Services and Ambulatory Surgical Care Benefit* • *Outpatient Diagnostic and Radiology Services Benefit* • *Outpatient Mental Health and Substance Abuse Services Benefit* • *Outpatient Rehabilitative and Cardiac Rehabilitative Services Benefit* • *Emergency Care Benefit* • *Urgent Care Benefit* • *Ambulance Services Benefit* • *Durable Medical Equipment and Prosthetics Benefit* *All Medicare Part B Benefits are based on per vist, except Ambulance Services Benefit, which is based on per trip, and Durable Medical Equipment and Prosthetics Benefit, which is based on per device.*			
Medicare Part B Deductible First $663 of Medicare-approved amounts	$0	100% of Medicare Part B Deductible	**$0**

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
Remainder of Medicare-approved amounts	80%	100% of the remaining Medicare Part B Coinsurance	**$0**
Part B Excess Charges for Non-Participating Medicare providers covers the difference between the 115% Medicare limiting fee and the Medicare-approved Part B charge	$0	100%	**$0**

ADDITIONAL SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
PREVENTIVE MEDICAL CARE & CANCER SCREENINGS[3] Coverage for expenses incurred by a covered person for physical exams, preventive screening tests and services, cancer screenings, and any other tests or preventive measures determined to be appropriate by the attending Physician. Refer to your Medicare and You handbook for more information on Preventive services.			
"Welcome to Medicare" Physical Exam -within first 12 months of Part B enrollment	100%	$0	**$0**
Annual Wellness Visit	100%	$0	**$0**
Vaccinations	100%	$0	**$0**
Preventive Care Cancer Screening Benefits[3]	Generally 100% for most preventive screenings. Some screenings subject to the Medicare Part B Deductible and Coinsurance	100% of remaining covered expenses Incurred not covered by Medicare	**$0**

GROUP RETIREE INSURANCE PLAN
SUMMARY OF COVERAGE FOR PREMIUM CHOICE PLAN

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
FOREIGN TRAVEL EMERGENCY Medically necessary emergency care services.			
Emergency services needed due to Injury or Sickness of sudden and unexpected onset during the first 60 days while traveling outside the United States.	$0	80% after $250 Deductible (to a lifetime maximum of $50,000)	**$250 Deductible and then 20% of expenses incurred** (to a lifetime maximum of $50,000, then 100% thereafter)

[1] Coverage amounts are valid from the policy effective date to December 31, 2018. This chart describes coverage that is only available to persons who are at least 65 and Medicare-eligible. Medicare amounts typically change January 1 of each year.

[2] A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Hospital does not include any institution or part thereof that is used primarily as a nursing home, convalescent home, or Skilled Nursing Facility; a place for rest, custodial, educational or rehabilitory care; a place for the aged; or, a place for alcoholism or drug addiction.

[3] If any of the cancer screening tests are not covered by Medicare, the plan will pay the usual and customary charges incurred. Please refer to your certificate for a full description of preventive screenings.

Please note this policy also may cover certain benefits mandated by the state where the employer is situsedor the state where you reside. Refer to your certificate for a description of any additional benefits.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. This brochure/presentation explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy as issued to the policyholder. Benefits are subject to state availability.

Not connected with or endorsed by the U.S. Government or the federal Medicare program.

Limitations & Exclusions: The Hartford's Insurance Plan does not cover any expense that is not a Medicare Eligible Expense or beyond the limits imposed by Medicare for such expenses or excluded by name or specific description by Medicare, except as specifically provided in the policy. The plan does not cover: Any part of a covered expense to the extent paid by Medicare; benefits payable under one benefit of the policy to the extent covered under another benefit of the policy; or expense incurred after coverage terminates, except as stated in the Extension-of-Benefits provision of the policy.

SAN MATEO ELECTRICAL WORKERS

CONVERTING RESERVE HOURS TO YOUR RETIREE RESERVE BANK

When you retire, the Plan office converts your accumulated hours in your hour bank as follows:

Your hours are converted to dollars for purposes of purchasing retiree coverage. For example, if you have a maximum bank of 1440 hours in your hour bank, that is equivalent to twelve months of coverage (12 months x 120 hours = 1440 hours)

The current monthly cost of the Active Plan for a self-funded participant is $1874.10, and for Kaiser, the monthly cost is $1911.06. The Plan multiplies $1874.10 x 12 months, which equals $22,489.20. For Kaiser Participants, the rate of $1911.06 x 12 months, which equals $22,932.72.

This amount is then used on your behalf to pay the retiree medical premiums for coverage under the Retiree medical plan. (If you have 11 months of coverage and an extra 30 hours, the extra 30 hours are not converted to dollars. The cost of coverage will likely increase each year. Moreover, the Board of Trustees has the right to change the 120 hours required for a month of coverage.

SAN MATEO ELECTRICAL WORKERS

RETIREE RATES

EFFECTIVE JUNE 1, 2020

DEFINITION		OLD RATE	NEW RATE
Early Retiree PPO	SINGLE	$480.00	$505.00
Early Retiree PPO w/Spouse under 65	2-PARTY	$841.00	$891.00
Early Retiree PPO w/Spouse over 65	2-PARTY	$771.00	$821.00
Early Retiree PPO Family	FAMILY	$1,033.00	$1,108.00
Early Retiree Kaiser	SINGLE	$350.00	$375.00
Early Retiree Kaiser w/Spouse under 65	2-PARTY	$642.00	$692.00
Early Retiree Kaiser w/Spouse over 65	2-PARTY	$538.00	$588.00
Early Retiree Kaiser	FAMILY	$884.00	$959.00
Early Retiree - Disabled	SINGLE	$136.00	$161.00
Early Retiree - Disabled w/Spouse under 65	2-PARTY	$338.00	$388.00
Early Retiree - Disabled w/Spouse over 65	2-PARTY	$203.00	$253.00
Medicare 65 or Older	SINGLE	$136.00	$161.00
Medicare 65 or Older w/Spouse Under 65	2-PARTY	$338.00	$388.00
Medicare 65-79 w/Spouse Under 65 + Children	FAMILY	$670.00	$745.00
Medicare 65 or Older w/Spouse 65 or Older	2-Party	$203.00	$253.00
Medicare 65-79 w/Spouse 65-79 + Children	FAMILY	$445.00	$520.00

CLAIM FOR REIMBURSEMENT
SAN MATEO ELECTRICAL WORKERS TRUST FUND
HEALTH REIMBURSENT CLAIM FORM

Name _____ Social Security #_____

Street Address _____

City, State, Zip Code_____

Complete only the sections that apply to the claim you are submitting for reimbursement. Part 1 is for Unreimbursed Medical Expenses, Part 2 is for Authorization to Deduct Self Payment Amounts from your HRA Account to continue coverage. Payment for Medical Reimbursement will be issued to you once a month, provided you have a balance in your HRA Account. ***Please note that the HRA Funds are part of the Trust and that an HRA Account balance is not a vested benefit.***

Part 1: UNREIMBURSED MEDICAL EXPENSES - Send Bills, Explanation of Benefits or other documents.

Date Incurred	Name of Service Provider	Expense Description	Person for Whom Expense Incurred	Net Amount
PLEASE READ CAREFULLY:			TOTAL AMOUNT CLAIMED:	

The undersigned participant in the plan certifies that all expenses for which reimbursement or payment is claimed by submission of this form are for covered medical expenses. The undersigned fully understands that he or she alone is fully responsible for the sufficiency, accuracy and veracity of all information relating to this claim which is provided by the undersigned, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including Federal, State or City Income Tax on amounts paid from the Plan which relate to such expense. It is the member's responsibility to keep copies of all claim forms and receipts for potential IRS Audits.

The undersigned certifies that the above Medical expenses have not been reimbursed and are not reimbursable under any other health plan coverage.

_____ _____

Employee's Signature **Date**

PART 2: AUTHORIZATION TO DEDUCT SELF PAY PREMIUM FROM EXTENDED RESERVE ACCOUNT

My signature below is authorization to have the monthly premium amount required for Active Member self payment, Retiree Premium or COBRA coverage to be deducted from my HRA Account. I understand that payment deduction from my HRA Account will continue only under the terms of the San Mateo Electrical Workers Health and Welfare Trust Fund rules of Self Payment and COBRA coverage. The authorization is for continuation of coverage as checked below. I may continue Medical Only Coverage or Medical and Dental Coverage. I may not continue Dental Only coverage.

Please check only one option:

I elect deduction of the required Medical Only Coverage: _____

I elect deduction of the required premium for Medical and Dental Coverage: _____

This authorization will remain in effect until the earliest of the following; a) such time as I am no longer eligible to continue coverage under the self pay rules or COBRA coverage, b) my HRA Account balance is exhausted or c) I rescind the authorization in writing. I understand if I rescind this authorization prior to the end of the period allowed by self pay rules, I can not later elect to use the HRA Account for any remainder of that entire period.

_____ _____

Employee's Signature **Date**

Mail claim form to: United Administrative Services, Attn: Danielle/Admin, PO Box 5057, San Jose, CA 95150-5057

SAN MATEO ELECTRICAL WORKERS
SHORT TERM DISABILITY PLAN

Once a member becomes disabled, they contact UAS to get the paperwork for Short Term Disability – Teresa Dickerson (408) 288-4507

To qualify for the Short Term Disability Plan, a member must have had Health & Welfare coverage for at least 12 months prior to the disability and must have active coverage the month of the disability.

There is a 30 day waiting period before STD benefits kick in.

After the 30 day waiting period, the member receives $1,000.00 per month for a maximum of 12 months. In addition, they get up to 12 months maximum of free coverage, meaning we freeze their hour bank, and give them free eligibility while they are disabled.

If the member is terminally ill and receiving hospice services, we can extend the free coverage only for an additional 3 months.

Local 617 does not have a Long Term Disability Plan. If the member is still disabled after 12 months, they get a letter from UAS asking them if they have a Social Security Disability Award. If they do, they can apply for their Pension. If they do not, there is no other benefit for them. They would then use up the rest of their reserve bank, and then go on to COBRA to continue benefits. When on COBRA with a disability, they are able to pay for 29 months, instead of the normal 18 months.

IBEW PENSION BENEFIT FUND

"IO PENSION"

- Earned because of your continuous IBEW membership.
- NOT EMPLOYERFUNDED

✓ Active "A" membership in the IBEW is required for participation in the Plan.

✓ You must no longer be actively employed in the Electrical Industry to start receiving benefits.

TO START RETIREMENT BENEFITS: Contact your Local Union business office 3 months prior to retiring.

✓ Normal Retirement: Age 65 - must have 5 years or more of continuous "A" membership.

✓ Optional Early Retirement: Age 62 - must have 20 years or more of continuous "A" membership.

✓ Disability Pension: Any Age - must have 20 years or more of continuous "A" membership and must have Social Security Disability Award.

Applying for Pension benefits or just have questions?? Contact your Local Union Office.

IBEW PENSION BENEFIT FUND (PBF)*				
	NORMAL	EARLY	**DISABILITY**	**VESTED**
Years of continuous IBEW membership to be eligible	5	20	20	20
Member's Retirement Age	65	62-64	Approximately 38 - 64	65
Restrictions	May not work in the Electrical Industry	May not work in the Electrical Industry	May not work at all	May not work in the Electrical Industry
Disincentives	None	Reduced Monthly Rate	Must await determination of disability	'Loss of Death and Disability Rights
Benefits effective January 1, 2007	$4.50 per month for each. full year of IBEW membership	Same as Normal less 6.66% for each year under age 65	Same as Normal	Same as Normal, less $4.50/mo. for each year Vested applicant is under age 65
Optional Spouse's Benefit	Eligible	Eligible	Eligible	Not Eligible

* Active "A" membership in the IBEW is required for participation in the Plan.