San Mateo County Electrical Construction Industry Health & Welfare and Retirement Plan Workshop

November 7, 2026

Thank you for joining us today,
Please make sure to **mute yourself upon entry**.
We will have a Q&A session after each presentation.

Pension

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Vesting Requirements

VESTING REQUIREMENTS

➤**Vesting:** you will earn 1/10th of vesting service for 100 hours of covered employment in a plan year (starting with 3/10 vesting service if you work 300-399 hours of covered employment), up to 1.00 vesting service credit for a 1,000 or more hours.

➤For any participant who has worked in covered employment on or after January 1, 2009, you will be a vested participant if you have three (3) years of covered employment without incurring a permanent break in service.

➤For participants who worked in covered employment prior to January 1, 2009, the plan required five (5) years of service.

Eligibility for Benefits

ELIGIBILITY FOR BENEFITS

When can you receive benefits?

To be entitled to receive your Plan benefits you must terminate your employment and satisfy one of the following requirements:

- **Normal retirement-age 65.** You attain age 65, the plan's normal retirement age, or later if you are not yet vested, at the fifth anniversary of your participation in the plan without a break in service. You are considered retired when you reach age 65 and work less than 40 hours in a month in the electrical construction industry in San Mateo County. (You will be required to certify under penalty of perjury that you are no longer working in the electrical construction industry in San Mateo County.)

- **Early retirement-age 55—thirty days without working**. You attain age 55, the plan's early retirement age and terminate your covered employment, or thereafter, and file a written certification under penalty of perjury that you have terminated or are intending to terminate your covered employment and/or any other employment in the electrical industry prior to your benefit commencement effective date. No distribution can be made until at least 30 business days have elapsed since your last date of covered employment. You should not be on the union's out-of-work list during that thirty-day period.

ELIGIBILITY FOR BENEFITS - CONTINUED

- **Permanent and total disability:** Regardless of your age if you are totally and permanently disabled, you may apply for the money credited to your individual account. You will be considered totally and permanently disabled only if you are entitled to a social security disability benefit (social security award).

- **Travelers:** An employee, known as a traveler, who terminates employment in the jurisdiction of IBEW 617, with an individual account balance of $7,000.00 or less is eligible to a transfer of the entire balance of his or her individual account to his or her IBEW home local with a defined contribution plan upon filing an application with the administration office.

- **Attainment of age 70:** You are entitled to a partial or total distribution of your individual account with the plan upon attainment of age 70 even if you continue to work in covered employment.

- **Signatory employer -59 ½:** An owner of a signatory employer who has not had any contributions made to the plan for six consecutive months is entitled to a distribution of the entire balance upon attainment of age 59 ½ so long he or she has not worked for any non-signatory employer in the electrical industry.

ELIGIBILITY FOR BENEFITS - CONTINUED

- **IRS required minimum distribution age:** Pursuant to the SECURE act 2.0 the age for required minimum distribution (RMD) has increased to age 73 for those participants who attain age 73 after December 31, 2022, and age 75 for participants who attains 73 after December 31, 2032 (if you attained age 70 ½ prior to January 1, 2020, your RMD age will remain at age 70 ½).

- **Terminally ill distributions – elimination of early withdrawal penalties:** A participant who is not working in covered employment who has been determined to be terminally ill (physician certifies the illness or condition reasonably expected to result in death in 84 months or less) is entitled to a distribution of his or her individual account.

- **Residents of federally declared disaster areas:** A participant living in a federally declared disaster area is entitled to a distribution of up to $22,000 for each declared disaster. The distribution request must be made within 180 days after the date of the federally declared disaster.

- **Caution-for participants returning to work after a total distribution—3-year vesting:** If you retire and receive a complete distribution of your pension benefits but later return to covered employment requiring contributions to the plan you must again meet the three-year vesting requirement.

Form of Benefits

FORMS OF BENEFITS

- **Partial/total lump-sum distribution:** you may elect a partial or total lump sum distribution of your account balance. There is no limit on the number of partial lump sum distributions. (The normal form of benefit for a married participant with an individual account balance greater than $7,000.00 is a 50% joint and survivor annuity. Thus, to be entitled to a partial or total lump sum distribution, spousal consent before a notary or a plan representative on a form provided by the plan is required.)

- **Rollover:** you may elect a partial or total rollover of your individual account balance to an IRA of your choice or to another tax-qualified retirement plan that will accept your rollover distribution.

- **Periodic monthly distributions:** you may elect a specific monthly payment in $100 increments or more. The periodic payments will terminate when the account has exhausted.

FORMS OF BENEFITS

- **Single life annuity-single participant:** under federal law the normal form of benefit for a single participant is a single life annuity, which is a series of monthly pension payments intending to extend for the balance of your life. Under the life annuity option, payments end when you die. A married participant, with spousal consent, also may select this form of benefit. If you choose this option, the plan will use your individual account balance to provide such annuity from an insurance company or other entity at then current market rates or determine your monthly benefit based on standard life expectancy tables as required under applicable law. Regardless, monthly payments made directly from the plan will terminate when your individual account balance reaches zero even if you live longer than the age projected under the life expectancy tables.

- **Joint and survivor annuity (50%, 75%, 100%):** a participant may elect a benefit providing monthly payments during the continued lifetime of and after the death of the employee but reduced to 50%, 75%, or 100% and payable to the spouse during the spouse's lifetime after the death of the participant.

FORMS OF BENEFITS

- **IRS Mandatory Distribution - age 73:** pursuant to internal revenue code requirements, upon attainment of april 1 of the year following the date you attain age 73 you will be required to take an annual required minimum distribution.

- **Note:** if you do not rollover your account, distributions from the plan are subject to the mandatory federal income tax withholding of 20%.

BENEFICIARY BENEFITS

If you pass before retirement or withdrawal of your Individual Account, your surviving spouse will be entitled to your benefits, unless the surviving spouse has signed a spousal waiver before a notary on forms provided by the Plan. For non-married Participants (and Participants for whom the spouse has signed a waiver of such benefits), benefits will be paid in accordance with your beneficiary designation form. However, If no beneficiary has been designated or no designated beneficiary has survived you, the balance in your account will be transferred to your spouse, if any, and if none, in equal shares to your children, natural or adopted; if none survive you, to your parents; then to your brothers and sisters; finally, to your estate if there are no survivors.

QUALIFIED DOMESTIC RELATIONS ORDER

Divorce or Child Support Order ("QDRO").

Pursuant to a Qualified Domestic Relations Order, a Court may award a former spouse, child or other dependent a portion or all your Individual Account. Payment may also be required by a Court order to be paid to a county or state child support agency. The Plan assesses a $500 QDRO administration fee, which is usually shared between the parties ($250each).

You may contact the Fund office for a sample order that maybe used in the preparation of Qualified Domestic Relations Order.

APPLICATION PROCEDURES

You should contact the Fund office to request an application **90 days prior to your retirement date**. You must fully complete the application and return to the Fund office with a copy of the following documents:

- Proof of age for the participant and spouse (Birth Certificate, Passport or Photo ID with a second form of ID)
- Marriage Certificate (if applicable)
- Divorce Documents (QDRO, Settlement agreement, final judgement)

Please allow 30 business days for processing. All applications are reviewed on an individual case basis.

ADDITIONAL RETIREMENT BENEFITS CONTACTS

NATIONAL ELECTRICAL BENEFIT FUND

(NEBF)

(301) 556-4300

NECA-IBEW PENSION FUND

(217) 875-0254

IBEW PENSION BENEFIT FUND
"IO PENSION"

(INFORMATION PROVIDED BY THE IBEW PENSION BENEFIT FUND)

These benefits are earned by participants for their continuous IBEW membership. This is NOT employer funded. To become eligible, you must meet the following requirements:

- The IBEW requires a participant to be an active "A" member.
- You must no longer be actively employed in the electrical industry to start receiving benefits.
- 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 a social security disability award.
- 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 IBEW LOCAL 617 office for more information.
- For applications and questions, please contact your local union office.

IBEW PENSION BENEFIT FUND (PBF)* (Information Provided by the IBEW Pension Benefit Fund)

	NORMAL	EARLY	DISABILITY	VESTED
Years of Continuous IBEW Membership to be Eligible	5	20	20	20
Members Retirement Age	65	62-64	38-64 (Approximately)	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.**

Q&A

Retiree Health & Welfare plan

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Insurance Benefits on the Retiree Plan

Rules to Qualify

- Must be at least 55 years old.
- Must have CURRENT eligibility at the time of retirement.
- 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.
- 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.
- If eligible for Medicare, must have Medicare Parts A and B.
- 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.

INSURANCE BENEFITS ON THE RETIREE PLAN

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 October 2025 coverage is due no later than September 25, 2025. 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

INSURANCE BENEFITS ON THE RETIREE PLAN

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 Reserved Hours to Retiree Reserve Bank

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 1,440 hours in your hour bank, that is equivalent to twelve months of coverage (12 Months x 120 Hours = 1,440 Hours).

The current monthly cost of the Active Plan for a Self-Funded and Kaiser participant is shown below:

Active Plan	Monthly	Yearly
Self Funded Plan	$2,048.90	$2,048.90 x 12 Months = $24,586.80
Kaiser Plan	$2,620.03	$2,620.03 x 12 Months = $31,440.36

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.

Retiree Rates

RETIREE HEALTH CARE RATES (AS OF JUNE 2026)

Categories		New Rate
Early Retiree PPO	SINGLE	$505.00
Early Retiree PPO w/Spouse under 65	2-PARTY	$891.00
Early Retiree PPO w/Spouse Over 65	2-PARTY	$821.00
Early Retiree PPO Family	FAMILY	$1,108.00
Early Retiree Kaiser	SINGLE	$375.00
Early Retiree Kaiser w/Spouse under 65	2-PARTY	$692.00
Early Retiree Kaiser w/Spouse over 65	2-PARTY	$588.00
Early Retiree Kaiser	FAMILY	$959.00
Early Retiree – Disabled	SINGLE	$161.00
Early Retiree – Disabled w/Spouse under 65	2-PARTY	$388.00
Early Retiree- Disabled w/Spouse over 65	2-PARTY	$253.00
Medicare 65 or Older	SINGLE	$161.00
Medicare 65 or Older w/Spouse Under 65	2-PARTY	$388.00
Medicare 65-79 w/Spouse Under 65 + Children	FAMILY	$745.00
Medicare 65 or Older w/Spouse 65 or Older	2-PARTY	$253.00
Medicare 65-79 w/Spouse 65-79 + Children	FAMILY	$520.00

Benefit Summaries

San Mateo Electrical Workers ACTIVES
Anthem Blue Cross PPO Self-Funded Plan Benefit Summary
2026–2027

	LEVEL ONE PPO PROVIDERS	LEVEL TWO OUT OF NETWORK
Deductible – Individual	$0	$250
Deductible – Family	$0	$500
Annual Out-of-Pocket Maximum	The out of pocket maximum is $1,250 per individual and $2,500 per family. Deductible and office visit copayments do not apply to the out of pocket maximum.	The out of pocket maximum is $2,000 per individual and $4,000 per family. Deductible and office visit copayments do not apply to the out of pocket maximum.
Lifetime Maximum	None	None
	BENEFITS FOR COVERED SERVICES	
PHYSICIAN SERVICES		
Office visits	$15 COPAYMENT	$15 COPAYMENT
Hospital/Skilled Nursing visits	90%	60%
Specialists	$15 COPAYMENT	$15 COPAYMENT
Surgeon/Asst. Surgeon	90%	60%
Anesthesiologist	90%	60%
Diagnostic X-ray & Labs	90%	60%
PREVENTIVE CARE		
Routine Physical Exam	100%	60%
Well Baby Care	100%	60%, Covered from birth to age 3
Immunizations	90%, Covered from birth to age 3	60%, Covered from birth to age 3
HOSPITAL/SURGICAL SERVICES		
Inpatient**	90%	60%
Outpatient	90%	60%
EMERGENCY SERVICES		
Ambulance	90%	90%
Emergency Room	90% after $50 copay Waived if Admitted	60% after $50 copay Waived if Admitted
MATERNITY SERVICES		
Hospital Benefits – Delivery**	90%	60%
Outpatient Physician Services	90%	60%
Surgical Services	90%	60%

PRESCRIPTION DRUGS		
Retail Purchase *Limit of 2 fills per medication at a retail pharmacy, not to exceed 30 day supplies for each fill*	$5 Generic/$15 Preferred Brand/$25 Non-Preferred Brand	$5 Generic/$15 Preferred Brand/$25 Non-Preferred Brand
Generic or Brand maximum amount	30 day supply	30 day supply
Save money with Mail Order!	Prescription Drugs are provided by SavRx	
Mail Order Purchase *Required for all maintenance medications, after 2 fills at a retail pharmacy, not to exceed 90 day supplies.*	$10 Generic and $30 Preferred Brand/$50 Non-Preferred Brand	$10 Generic and $30 Preferred Brand/$50 Non-Preferred Brand
Generic or Brand maximum amount	90 day supply	90 day supply
IMPORTANT: The IBEW Local 617 drug plan requires utilization of the mail order pharmacy for medications taken on a long term basis. Copayments increase two fold upon the third prescription fill for any medication not filled by the plan's mail order pharmacy. Copayments are reduced by one third for ninety day supplies obtained through the mail order pharmacy. All new (first time) prescriptions for long term medications should first be filled at a local retail pharmacy for the first two fills, to evaluate efficacy and tolerability, before ninety day maintenance supplies are ordered through the mail order pharmacy.		
SUBSTANCE ABUSE TREATMENT		
	For inpatient or outpatient services for substance abuse treatment, please contact UAS at 408-288-4400.	For inpatient or outpatient services for substance abuse treatment, please contact UAS at 408-288-4400.
Hospital Benefits **	90%, max 30 days per calendar year	60%, max 30 days per calendar year
Outpatient Physician Services	90%*	60% *
MENTAL AND NERVOUS (EXCLUDES SEVERE MENTAL DISORDERS)		
Hospital Benefits **	90%, max 30 days per calendar year	60%, max 30 days per calendar year
Outpatient Physician Services	90%*	60%*
CHIROPRACTIC AND ACUPUNCTURE SERVICES	90%*	60%*
CONTINUED CARE SERVICES		
Home Health Care	90%*	60%*
Skilled Nursing Facility**	Following discharge from an acute care facility, plan pays 90%	Following discharge from an acute care facility, plan pays 60%
PHYSICAL THERAPY	90%*	60%*
SPEECH THERAPY	90%*	60%*

* Note: There is a 30 visit per calendar year limit for these services.

** Note: Precertification of services is required for non-emergency hospital admissions.

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Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (6/1/26—5/31/27)

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	$1,000 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
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$10 per visit
Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$100 per admission
Emergency Services	**You Pay**
Emergency department visits	$35 per visit
Ambulance Services	**You Pay**
Ambulance Services	$50 per trip
Prescription Drug Coverage	**You Pay**
This plan covers Medicare Part D prescription drugs in accord with our Part D formulary.	
Initial coverage stage—until you have spent $2,100 in 2026. (If you spend $2,100, you move on to the catastrophic coverage stage)	$10 for up to a 100-day supply
Catastrophic coverage stage	No charge
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
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
Fitness benefit – One Pass® (includes access to in-network gyms and one home fitness kit per calendar year)	No charge

***Summary of Benefits* booklet**

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*.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 06/01/2026-05/31/2027

KAISER PERMANENTE® : TRADITIONAL PLAN

Coverage for: Individual/Family | Plan Type: HMO

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 see https://kp.org/plandocuments or call 1-800-278-3296 (TTY: 711). 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.healthcare.gov/sbc-glossary/ or call 1-800-278-3296 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,500 Individual / $3,000 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?	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.	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.kp.org or call 1-800-278-3296 (TTY: 711) 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 network. You will pay the most if you use an 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?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 / visit	Not Covered	None
	Specialist visit	$15 / visit	Not Covered	None
	Preventive care/ screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRI's)	No Charge	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.kp.org/formulary	Generic drugs (Tier 1)	$10 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines.
	Preferred brand drugs (Tier 2)	$10 / prescription	Not Covered	Up to a 100-day supply retail and mail order. Subject to formulary guidelines.
	Non-preferred brand drugs (Tier 2)	$10 / prescription	Not Covered	The cost sharing for non-preferred brand drugs under this plan aligns with the cost sharing for preferred brand drugs (Tier 2), when approved through the formulary exception process.
	Specialty drugs (Tier 4)	$10 / prescription	Not Covered	Up to a 30-day supply retail. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$15 / procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	Physician/surgeon fees are included in the Facility fee.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	$50 / visit	$50 / visit	None
	Emergency medical transportation	$50 / trip	$50 / trip	None
	Urgent care	$15 / visit	Not Covered	Non-Plan providers covered when temporarily outside the service area: $15 / visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 / admission	Not Covered	None
	Physician/surgeon fee	No Charge	Not Covered	Physician/surgeon fees are included in the Facility fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 / individual visit. No Charge for other outpatient services	Not Covered	Mental / Behavioral Health: $7 / group visit; Substance Abuse: $5 / group visit.
	Inpatient services	$100 / admission	Not Covered	None
If you are pregnant	Office visits	No Charge	Not covered	Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge	Not Covered	Professional services are included in the Facility services.
	Childbirth/delivery facility services	$100 / admission	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	3 visit limit / day, 100 visit limit / year.
	Rehabilitation services	Inpatient: $100 / admission; Outpatient: $15 / visit	Not Covered	None
	Habilitation services	$15 / visit	Not Covered	None
	Skilled nursing care	No Charge	Not Covered	100 day limit / benefit period.
	Durable medical equipment	20% coinsurance	Not Covered	Requires prior authorization.
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge for refractive exam	Not Covered	None
	Children's glasses	No Charge	Not Covered	Up to $175 glasses or contact lenses (instead of glasses) / 24 months.
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Cosmetic surgery
- Dental Care (Adult & Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture (plan provider referred)
- Bariatric surgery
- Chiropractic care (40 visit limit / year)
- Infertility treatment
- Routine eye care (Adult)

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 shown in the chart below. 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 on how 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 the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-278-3296 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
California Department of Insurance	1-800-927-HELP (4357) or www.insurance.ca.gov
California Department of Managed Healthcare	1-888-466-2219 or www.dmhc.ca.gov

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 1-800-788-0616 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-757-7585 (TTY: 711)

PENNSYLVANIA DUTCH (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-278-3296 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-278-3296 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-278-3296 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-800-278-3296 (TTY: 711)

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

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) copayment	$100
Other (blood work) copayment	$0

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	$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$160**

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) copayment	$100
Other (blood work) copayment	$0

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	$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$660**

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$100
Other (x-ray) copayment	$0

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	$2,800
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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

Blue Shield

PLAN G

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 $1,736	$1,736 (Part A deductible)	$0
61st through 90th day	All but $434 a day	$434 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 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

MEDICARE (PART B)
MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $283 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 $283 of Medicare-approved amounts*	$0	$0	$283 (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 (Part B)	$0	All costs	$0
Next $283 of Medicare-approved amounts*	$0	$0	$283 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TEST FOR DIAGNOSTIC SERVICES			
	100%	$0	$0

PLAN G

PARTS A & B

* Once you have been billed $283 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 $283 of Medicare-approved amounts*	$0	$0	$283 (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

Other benefits – not covered by Medicare (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
ACUPUNCTURE AND CHIROPRACTIC SERVICES - Your acupuncture and chiropractic services benefits are administered by American Specialty Health Plans of California, Inc. (ASH Plans). The benefits covered under this plan must be received from ASH Participating Providers. ASH Participating Providers may be located through an online directory at **blueshieldca.com**. Click on *Find a doctor*.			
Up to 20 visits per calendar year for acupuncture and chiropractic Services combined	Not Covered	100%	$0
PHYSICIAN CONSULTATION BY PHONE OR VIDEO THROUGH TELADOC HEALTH			
	$0	$0	$0 per consult
OVER-THE-COUNTER ITEMS THROUGH CVS Eligible over-the-counter (OTC) items are available through the OTC Items Catalog, at **blueshieldca.com/medicareOTC. Limitations may apply. Refer to the OTC Items Catalog for more information.**			
Up to two orders per quarter	$0	Up to $100 allowance per quarter	All costs above the $100 allowance per quarter

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 the $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
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-Network:** 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. EPIC Participating Providers are listed at **blueshieldca.com/medicare/providerdirectory**. 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 Benefits every year include: • One in-person routine hearing exam • Hearing aid instrument o Up to two hearing aids delivered in-person through a network hearing aid provider o Choice of private-labeled Silver (mid-level), Gold (advanced-level), or Platinum (premium-level) technology hearing aid models o Silver technology level hearing aids: – available in behind-the-ear and receiver-in-the-ear hearing aid styles only o Gold technology level hearing aids: – available in multiple styles: in-the-ear, in-the-canal, completely-in-canal, behind-the-ear, and receiver-in-the-ear hearing aid styles o Platinum technology level hearing aids: – available in multiple styles: in-the-ear, in-the-canal, completely-in-canal, behind-the-ear, and receiver-in-the-ear hearing aid styles o All technology levels include: – one consultation	 $0 $0	 100% $0	 $0 **Silver Technology Level** $449 per hearing aid **Gold Technology Level** $699 per hearing aid **Platinum Technology Level** $999 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. EPIC Participating Providers are listed at **blueshieldca.com/medicare/providerdirectory**. 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.			
– up to three follow-up visits for hearing aid fitting, consultation, device check, and adjustment for no additional fee within 12 months of purchase – standard ear molds and impressions are available as needed – charging case for rechargeable battery models or a two-year supply of batteries per hearing aid; and – three-year extended warranty.			

Medicare Supplement Plan Application

Here's how to apply

1. Provide ALL requested information and print clearly in all capital letters in black ink.
2. Sign and date in all places indicated.
3. Within 30 days of your signature date, please submit your completed application to:
   Fax (844) 266-1850 **Email** msinstall@blueshieldca.com
   Mail Medicare Supplement Installation
   P.O. Box 3008
   Lodi, CA 95241-1912
4. It is required that a signed copy of this contract is made for your records. Be sure to keep the second copy of this application with all other important Blue Shield of California documents and information.

If you are a current member interested in transferring to a Medicare Supplement plan of equal or lesser value outside your enrollment period or to a richer benefit plan at any time, you must complete this application.

Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first became eligible for Medicare benefits due to disability before January 1, 2020.

Personal information

Last name:	First name:	Middle initial:
Date of birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female	
Phone number:	Phone Type: ☐ Landline ☐ Mobile	
Home address:		
City:	State:	ZIP code:

Language preference:
☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Email address:

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Mailing address (if different from above):		
City:	State:	ZIP code:
Billing address (if different from above):		
City:	State:	ZIP code:

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 the Part A Deductible	100% of Medicare Part A Deductible	$0
61st through 90th day	All but 25% of Medicare Part A Deductible per day	100% of Medicare Part A Coinsurance	$0
91st through 150th day (60 day Lifetime Reserve Period)	All but 50% of Medicare Part A Deductible 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 12.5% of Medicare Part A Deductible 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



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	$0	100% of Medicare Part B Deductible	$0
Remainder of Medicare-approved amounts	80%	100% of the remaining Medicare Part B Coinsurance	$0



SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
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] 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.

Other Benefits

San Mateo Electrical Workers Health & Welfare Trust Fund

Ameritas

Active Member Dental Plan Summary

Effective Date: 9/1/2024

	In Network	Out of Network
Plan Benefit		
Type 1	100%	100%
Type 2	90-95-100%	75%
Type 3	90%	75%
Deductible	$0/Calendar Year Waived Type 1	$50/Calendar Year Type 2 & 3 Waived Type 1
	No Family Maximum	$100/family
Maximum *(per person)*	$3,000 per calendar year	$3,000 per calendar year
Allowance	Discounted Fee	90th U&C
Ameritas Rewards®	Included	Included
Waiting Period	None	None

Orthodontia Summary - Adult and Child Coverage

	In Network	Out of Network
Allowance	Discounted Fee	U&C
Plan Benefit	90%	75%
Lifetime Maximum *(per person)*	$2,500	$2,500
Ameritas Rewards℠ Lifetime *(per person)*	$400 New Treatment Plan and Services Only	$400 New Treatment Plan and Services Only
Waiting Period	None	None

***Maximum is lifetime for both in network and out of network combined.*

Sample Procedure Listing *(Current Dental Terminology © American Dental Association.)*

In Network

Type 1

- Routine Exam (3 per benefit period)
- Bitewing X-rays (2 per benefit period)
- Full Mouth/Panoramic X-rays (1 in 5 years)
- Periapical X-rays
- Cleaning (3 per benefit period)
- Fluoride (2 per benefit period)
- Space Maintainers

Type 2

- Sealants (age 15 and under)
- Fillings for Cavities
- Restorative Composites (anterior and posterior teeth)
- Endodontics (nonsurgical)
- Endodontics (surgical)
- Periodontics (nonsurgical)
- Periodontics (surgical)
- Simple Extractions
- Complex Extractions
- Anesthesia

Type 3

- Onlays
- Crowns (1 in 5 years per tooth)
- Crown Repair
- Denture Repair
- Implants
- Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

Out of Network

Type 1

- Routine Exam (3 per benefit period)
- Bitewing X-rays (2 per benefit period)
- Full Mouth/Panoramic X-rays (1 in 5 years)
- Periapical X-rays
- Cleaning (3 per benefit period)
- Fluoride (2 per benefit period)
- Space Maintainers

Type 2

- Sealants (age 15 and under)
- Fillings for Cavities
- Restorative Composites (anterior and posterior teeth)
- Endodontics (nonsurgical)
- Endodontics (surgical)
- Periodontics (nonsurgical)
- Periodontics (surgical)
- Simple Extractions
- Complex Extractions
- Anesthesia

Type 3

- Onlays
- Crowns (1 in 5 years per tooth)
- Crown Repair
- Denture Repair
- Implants
- Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

San Mateo Electrical Workers Health & Welfare Trust Fund

Ameritas

Active Member Dental Plan Summary: Additional Savings and Benefits Available

Incentive Coinsurance

Plans with coinsurance levels that progressively increase are designed to reward your loyal employees: The longer they stay on the plan, the higher their coinsurance. As long as plan members have at least one dental claim submitted each benefit period, they continue to advance one coinsurance level until they reach the plan's highest benefit level. If a plan member fails to have at least one dental claim submitted during any benefit year, he or she will revert back to the beginning coinsurance benefit. If that happens, members can progress back to higher coinsurance levels in subsequent years by submitting at least one dental claim each benefit year.

Ameritas Rewards℠

Ameritas Rewards is an enhanced product that offers an increased maximum for hearing, LASIK, orthodontia and vision as well as dental. It allows members to utilize unused dental maximum carryover amounts from previous years towards dental benefits or other lines of coverage included in a plan. Employees and their covered dependents may accumulate dental rewards with an unlimited maximum carryover amount. These rewards can be used to increase the maximum for the other lines of coverage which can then be used for certain covered services or materials subject to applicable deductible, coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. A member is eligible to earn rewards again the next year.

Benefit Threshold	$750	Dental benefits received for the year cannot exceed this amount.
Annual Carryover Amount	$400	Ameritas Rewards amount is added to the following year's maximum.
Annual PPO Bonus	$200	Additional bonus is earned if the member sees a network provider.
Maximum Carryover	Unlimited	Maximum possible accumulation for Dental Rewards and PPO Bonus combined.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Dental Network Information

To find a provider, visit ameritas.com and select **FIND A PROVIDER**, then **DENTAL**. Enter your criteria to search by location or for a specific dentist or practice. California Residents: When prompted to select your network, choose the Ameritas Network found on your ID Card or contact Customer Connections at 800-487-5553.

Your provider network is **Ameritas Classic Network**.

Ameritas Information

We're Here to Help

This plan was designed specifically for the associates of San Mateo Electrical Workers Health and Welfare Trust Fund. At Ameritas Group, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 5 a.m. to 10:00 p.m. (Pacific Time) Monday through Thursday, and 5 a.m. to 4:30 p.m. on Friday.

You can speak to them by calling toll-free: **800-487-5553**.

For plan information any time, access our automated voice response system or go online to **ameritas.com**.

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San Mateo Electrical Workers Health & Welfare Trust Fund

Ameritas

Active Member Dental Plan Summary: Additional Savings and Benefits Available

SoundCare Summary

Coinsurance	
Annual Hearing Exam	100%
Hearing Aid	50%
Hearing Aid Maintenance	100%
Deductible	None
Maximum *(per benefit period)*	
Annual Hearing Exam	Up to $75
Hearing Aids *(both ears)*	
Year One	Up to $200
Year Two	Up to $600
Year Three	Up to $800
Hearing Aid Maintenance	Up to $40

Additional Hearing Savings

With your Ameritas plan, you can receive hearing aid discounts through Great Hearing Benefits at their 4,500+ hearing care locations nationwide. Call 877-683-9495 for your free hearing consultation today. This savings arrangement is not insurance. It is available to members at no additional cost to their plan premium.

Highlights include: hearing exam for only $50 (saves you $100 off the industry average of $150), up to 50% off retail pricing on today's top hearing technology, plus a satisfaction guarantee and warranty service. Visit greathearingbenefits.com/ameritas to learn more.

Rx Savings

Our valued plan members and their covered dependents can save on prescription medications at over 60,000 pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

To receive this Rx discount, Ameritas plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

Eyewear Savings

Ameritas plan members may receive up to 10% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. Members may also bring in their current vision prescription from any vision care provider and purchase eyewear at Walmart. This savings arrangement is not insurance: it is available to members at no additional cost to their plan premium.

To receive the eyewear savings identification card, Ameritas plan members can visit ameritas.com and sign-in (or create) a secure member account. Members must present the Ameritas Eyewear Savings Card at time of purchase to receive the discount.

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San Mateo Electrical Workers Health and Welfare Trust Fund

Ameritas

Retiree Dental Plan Summary

Effective Date: 9/1/2024

Plan Benefit	In Network	Out of Network
Type 1	100%	100%
Type 2	90-95-100%	75%
Type 3	90%	75%
Deductible	$50/Calendar Year Type 2 & 3 Waived Type 1 $100/family	$50/Calendar Year Type 2 & 3 Waived Type 1 $100/family
Maximum *(per person)*	$3,000 per calendar year	$3,000 per calendar year
Allowance	Discounted Fee	90th U&C
Ameritas Rewards®	Included	Included
Waiting Period	None	None

Orthodontia Summary - Adult and Child Coverage

	In Network	Out of Network
Allowance	Discounted Fee	U&C
Plan Benefit	90%	75%
Lifetime Maximum *(per person)*	$2,500	$2,500
Ameritas Rewards℠ Lifetime *(per person)*	$400 New Treatment Plan and Services Only	$400 New Treatment Plan and Services Only
Waiting Period	None	None

***Maximum is lifetime for both in network and out of network combined.*

Sample Procedure Listing *(Current Dental Terminology © American Dental Association.)*

In Network

Type 1

- Routine Exam (3 per benefit period)
- Bitewing X-rays (2 per benefit period)
- Full Mouth/Panoramic X-rays (1 in 5 years)
- Periapical X-rays
- Cleaning (3 per benefit period)
- Fluoride (2 per benefit period)
- Space Maintainers

Type 2

- Sealants (age 15 and under)
- Fillings for Cavities
- Restorative Composites (anterior and posterior teeth)
- Endodontics (nonsurgical)
- Endodontics (surgical)
- Periodontics (nonsurgical)
- Periodontics (surgical)
- Simple Extractions
- Complex Extractions
- Anesthesia

Type 3

- Onlays
- Crowns (1 in 5 years per tooth)
- Crown Repair
- Denture Repair
- Implants
- Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

Out of Network

Type 1

- Routine Exam (3 per benefit period)
- Bitewing X-rays (2 per benefit period)
- Full Mouth/Panoramic X-rays (1 in 5 years)
- Periapical X-rays
- Cleaning (3 per benefit period)
- Fluoride (2 per benefit period)
- Space Maintainers

Type 2

- Sealants (age 15 and under)
- Fillings for Cavities
- Restorative Composites (anterior and posterior teeth)
- Endodontics (nonsurgical)
- Endodontics (surgical)
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San Mateo Electrical Workers Health and Welfare Trust Fund

Ameritas

Retiree Dental Plan Summary

Incentive Coinsurance

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While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

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San Mateo Electrical Workers Health and Welfare Trust Fund

Ameritas

Retiree Dental Plan Summary: Additional Savings and Benefits Available

SoundCare Summary

Coinsurance	
Annual Hearing Exam	100%
Hearing Aid	50%
Hearing Aid Maintenance	100%
Deductible	None
Maximum *(per benefit period)*	
Annual Hearing Exam	Up to $75
Hearing Aids *(both ears)*	
Year One	Up to $200
Year Two	Up to $800
Year Three	Up to $800
Hearing Aid Maintenance	Up to $40

Additional Hearing Savings

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Highlights include: hearing exam for only $50 (saves you $100 off the industry average of $150), up to 50% off retail pricing on today's top hearing technology, plus a satisfaction guarantee and warranty service. Visit greathearingbenefits.com/ameritas to learn more.

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To receive this Rx discount, Ameritas plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

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Ameritas plan members may receive up to 10% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. Members may also bring in their current vision prescription from any vision care provider and purchase eyewear at Walmart. This savings arrangement is not insurance: it is available to members at no additional cost to their plan premium.

To receive the eyewear savings identification card, Ameritas plan members can visit ameritas.com and sign-in (or create) a secure member account. Members must present the Ameritas Eyewear Savings Card at time of purchase to receive the discount.

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VSP

vsp vision care

Make Eye Health a Priority with VSP!



Your health comes first with VSP and ELECTRICAL WORKERS H & W SAN MATEO COUNTY (IBEW LOCAL 617). Take a look at your VSP vision care coverage.

VSP members save an annual average of

$489*

More Ways to Save

Extra $20 to spend on Featured Frame Brands†

bebe Calvin Klein COLE HAAN

DRAGON FLEXON LONGCHAMP

and more

Up to 40% savings on lens enhancements‡

See all brands and offers at **vsp.com/offers**.

Create an account today. Questions?

vsp.com

800.877.7195 (TTY: 711)

Scan QR code or visit **vsp.com** to learn more.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network doctor can detect signs of more than 270 health conditions during your annual eye exam—including diabetes and high blood pressure, as well as eye conditions such as glaucoma and diabetic eye disease.**

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

VSP PREMIER edge

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

eyeconic by VSP

Save on Featured Frame Brands when you shop on Eyeconic®, the VSP in-network online eyewear store.

Getting started is easy!

Let your plan do the most it can. When you create an account on **vsp.com**, you can view your in-network coverage details, find a VSP network doctor that is right for you, and discover extra savings to maximize your benefits.

†Frame brands and promotion subject to change. Only available to VSP members with applicable plan benefits. Only available at in-network locations. Members who participate in a Medicaid/state-funded plan are not eligible. ‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

*Based on state and national averages for eye exams and most commonly purchased brands. This represents the average savings for a VSP member with a full-service plan at an in-network provider. Your actual savings will depend on the eyewear you choose, the plan available to you, the eye doctor you visit, your copays, your premium, and whether it is deducted from your paycheck pre-tax. Source: VSP book-of-business paid claims data for Aug-Jan of each prior year. **"Full Picture of Eye Health, American Optometric Association, 2020. +Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. VSP Premier Edge® is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Visionworks, Eyeconic, and Eyemart Express family of stores are VSP-affiliated companies.

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VSP, Eyeconic, and WellVision Exam are registered trademarks, and VSP LightCare™ and VSP Premier Edge are trademarks of Vision Service Plan. All other brands or marks are the property of their respective owners. 186668 VCCM

Classification: Restricted

Your VSP Vision Benefits Summary

Prioritize your health and your budget with a VSP plan through ELECTRICAL WORKERS H & W SAN MATEO COUNTY (IBEW LOCAL 617).

Provider Network:
VSP Choice
Effective Date:
06/01/2025

vsp vision care

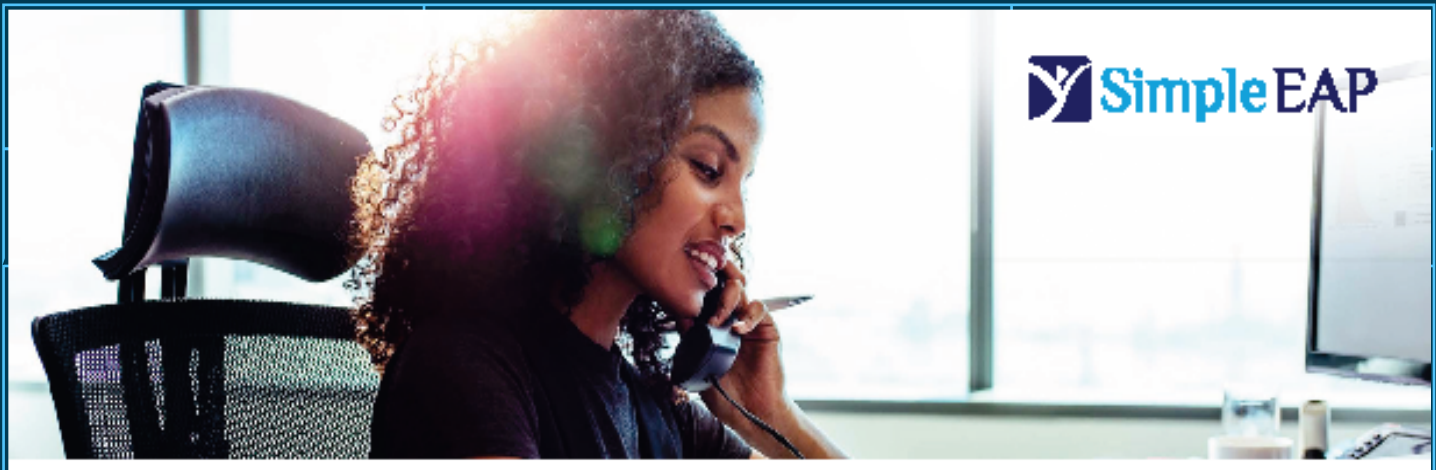
BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP DOCTOR			
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening	$10 Up to $39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details.	$20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	See frame and lenses
FRAME*	• $270 Featured Frame Brands allowance • $250 frame allowance • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Impact-resistant lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175 $0	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $200 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
VSP LIGHTCARE™†	• $250 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts	$25	Every 24 months
PROTEC SAFETY® (EMPLOYEE-ONLY COVERAGE)			
FRAME*	• Fully covered when you choose a safety frame from your VSP doctor's ProTec Eyewear® collection • $65 frame allowance for any other safety frame • 20% savings on the amount over your allowance • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	Combined with exam	Every 24 months
LENSES	• Prescription single vision, lined bifocal, and lined trifocal • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	Combined with exam	Every 12 months
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.		
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.		
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers/special-offers/hearing-aids** for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.		

COVERAGE WITH AN OUT-OF-NETWORK DOCTOR

With so many in-network choices, VSP makes it easy to maximize your benefits. Choose from our large doctor network including private practice and retail locations. Plus, you can shop eyewear online at Eyeconic®. Log in to **vsp.com** to find an in-network doctor. Your plan provides the following out-of-network reimbursements:

Exam ..... up to $45	Lined Bifocal Lenses ..... up to $50	Progressive Lenses ..... up to $50
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $65	Contacts ..... up to $105
Single Vision Lenses ..... up to $30		

Simple Therapy



Emotional Wellbeing and Work-Life Balance Resources To Keep You at Your Best

SimpleEAP offers expert guidance to help you and your family address and resolve everyday issues

In-the-moment support

Reach a licensed clinician by phone 24/7/365 when you call for assistance.

Short-term counseling

Access no-cost in-person or virtual (video) counseling sessions to resolve emotional concerns such as stress, anxiety, depression, burnout or substance use.

Coaching

Get assistance from a Coach to boost your emotional fitness, learn healthy habits, establish new routines, build your resilience and more.

Work-life benefits

Receive expert consultations for financial and legal issues. Work-life specialists also provide convenience referrals for everyday needs such as child or elder care, pet care, home improvement or auto repair.

Confidentiality

Strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.

Start with Mental Health Navigator

Take the guesswork out of your emotional fitness! Visit your web portal or mobile app to complete the short Mental Health Navigator assessment. You'll instantly receive personalized guidance to access care and support.



Your web portal and mobile app

- Create a personal profile to quickly access support from a licensed clinician
- Receive recommendations and care options based on your unique needs
- Exchange text messages with a Coach
- Attend anonymous group support sessions on a variety of topics
- Strengthen your mental health and wellbeing at your own pace with self-guided digital therapy
- Discover flash courses, self-assessments, financial calculators, career resources, articles, tip sheets and videos

Download the mobile app today!

888-425-4800

simpleeap.com

Group Code: ibewlocal617

LOCAL UNION 617
INTERNATIONAL BROTHERHOOD
OF ELECTRICAL WORKERS

SAN MATEO COUNTY
ELECTRICAL WORKERS JOINT TRUST FUNDS

SAN MATEO COUNTY CHAPTER
NATIONAL ELECTRICAL
CONTRACTORS ASSOCIATION

July 2026

TO: ALL PARTICIPANTS & DEPENDENTS

RE: SUMMARY OF MATERIAL MODIFICATIONS ("SMM") TO THE SAN MATEO ELECTRICAL WORKERS HEALTH CARE PLAN

The Board of Trustees of the San Mateo Electrical Workers Health Care Plan ("Plan") is pleased to provide you with the following summary of changes/clarifications (called a Summary of Material Modification ("SMM"), to the Plan rules, also known as the Summary Plan Description ("SPD"). In accordance with the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), this document serves as a SMM. Please review the important changes described below.

THIS SMM TO THE PLAN SUPPLEMENTS THE RESTATED SPD WHICH IS ALSO THE PLAN DOCUMENT THAT WAS SEPARATELY PROVIDED TO YOU. YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR COPY OF THE RESTATED SPD/PLAN DOCUMENT!!

CLARIFYING PLANAMENDMENT –
Article VI. SELF-FUNDED MEDICAL BENEFITS-ANTHEM BLUE CROSS-
($15 Co-payment arrangement for Mental Health, Behavioral Health & Substance Abuse Benefits- Via Simple Therapy, Effective immediately!)

Effective immediately, the Self-funded Plan's Mental Health, Behavioral Health Program & Substance Abuse Treatment benefits (through Simple Therapy) cost-sharing arrangement has been changed from a *coinsurance* (defined as a percentage of the service cost you pay after meeting any applicable deductible) to a *copayment* (defined as a fixed fee you pay for services) arrangement for both in-network and out-of-network services. Below is a summary of the copayment changes. If you have any questions regarding your behavioral health benefits, please contact Simple Therapy's administrative services at **(888) 425-4800.** For questions on billing, please contact the Trust Fund office at **(408) 288-4400 or (800) 541-8059.**

ACTIVE PPO MEDICAL PLAN

Mental Health/Behavioral Health & Substance Abuse Treatment	LEVEL ONE PPO PROVIDERS	LEVEL TWO OUT OF NETWORK
Inpatient	$15 copayment/visit	$15 copayment/visit
Outpatient	$15 copayment/visit	$15 copayment/visit

EARLY RETIREE PPO MEDICAL PLAN

Mental Health/Behavioral Health & Substance Abuse Treatment	LEVEL ONE PPO PROVIDERS	LEVEL TWO OUT OF NETWORK
Inpatient	$15 copayment/visit	$15 copayment/visit
Outpatient	$15 copayment/visit	$15 copayment/visit

APPRENTICE PPO MEDICAL PLAN

Mental Health/Behavioral Health & Substance Abuse Treatment	LEVEL ONE PPO PROVIDERS	LEVEL TWO OUT OF NETWORK
Inpatient	$20 copayment/visit	$20 copayment/visit
Outpatient	$20 copayment/visit	$20 copayment/visit

PRE-APPRENTICE PPO MEDICAL PLAN

Mental Health/Behavioral Health & Substance Abuse Treatment	LEVEL ONE PPO PROVIDERS	LEVEL TWO OUT OF NETWORK
Inpatient	$20 copayment/visit	$20 copayment/visit
Outpatient	$20 copayment/visit	$20 copayment/visit

GRANDFATHERED HEALTH PLAN REMINDER

The Board of Trustees believes that the Plan is a "Grandfathered health plan" under the Affordable Care Act ("Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that Act was enacted. Being a grandfathered health plan means that your Plan is not required to include certain consumer protections of the Act that apply to other plans, for example, requiring the provision of preventive health services without any cost sharing. Grandfathered health plans must comply, however, with certain other consumer protections in the Act, such as the elimination of annual and lifetime limits on the Plan's Essential Health Benefits. (For a definition of what constitutes as Essential Health Benefits please visit *www.Healthcare.gov/glossary/essential-health-benefits).*

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Office at (408) 288-4400. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 1–866–444–3272 or *www.dol.gov/ebsa/healthreform*. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Please contact the Trust Fund Office at (408) 288-4400 or (800) 541-8059, if you have any questions.

Respectfully submitted,
Fund Manager On Behalf of the Board of Trustees

Sleep Apnea

Obstructive Sleep Apnea is a sleep disorder in which breathing is briefly and repeatedly interrupted during sleep. The "apnea" in Sleep Apnea refers to a breathing pause that lasts at least ten seconds. Obstructive sleep apnea occurs when the muscles in the back of the throat fail to keep the airway open, despite efforts to breathe.

Obstructive Sleep Apnea, or simply, Sleep Apnea, can cause fragmented sleep and low blood oxygen levels. For people with Sleep Spnea, the combination of disturbed sleep and oxygen starvation may lead to hypertension, heart disease, stroke and a multitude of other medical problems. Sleep Apnea also increases the risk of drowsy driving. More than 50 million American adults have Sleep Apnea. Currently only 10% are being properly diagnosed.

What Causes Sleep Apnea?

There are a number of factors that increase risk, including having a small upper airway (or large tongue, tonsils or uvula), being overweight, having a recessed chin, a small jaw, a large overbite, and or crowded narrow dental arches. There are also a correlations to large neck sizes (17 inches or greater in a man, or 16 inches or greater in a woman), smoking and alcohol use, being age 40 or older, and certain ethnicities. Also, OSA seems to run in some families, suggesting a possible genetic basis.

Sleep Apnea Symptoms

Chronic snoring is a strong indicator of sleep apnea and should be evaluated by our Sleep Group health professionals. Since people with sleep apnea tend to be sleep deprived, they may suffer from sleeplessness and a wide range of other symptoms such as difficulty concentrating, depression, irritability, sexual dysfunction, learning and memory difficulties, and falling asleep while at work, on the phone, or driving. Left untreated, symptoms of sleep apnea can include disturbed sleep, excessive sleepiness during the day, high blood pressure, heart attack, congestive heart failure, cardiac arrhythmia, stroke or depression.

Treatment for Sleep Apnea

If you at all suspect you may have Sleep Apnea, reach out and make an appt to be screened by our Sleep Group Doctors at ***Aloha Sleep* Group.** They are a multi-disciplinary team of both Dentists and Physicians dedicated to treating Sleep Disorders. They will fully assess your risks of having Sleep Apnea, and be able to provide simple treatments to help you.

Dr Terry Codington Dentist ,UOP-SF Dental, Invisalign Global Faculty, American Academy of Sleep *Medicine*

Dr Mark Abramson Dentist, Univ Maryland, Board Cert. TMJ, Diplomate American Academy Dental Sleep

Dr Michael Ricupito, Orthodontist, UOP-SF Dental, UCLA Board Certified Orthodontist

Dr Kin Yuen , Stanford School of Medicine, Board Certified Sleep Physician

Aloha Sleep Group 424 N San Mateo Dr. Suite 300 San Mateo, Ca.

650-772-5642

Fertility Benefit

Fertility Services

Diagnosis and treatment of infertility

Description of Diagnosis and Treatment of Infertility Services	Copayment / Coinsurance
Office visits	$15 per visit
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	$15 per procedure
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	$15 per procedure
Outpatient imaging	No charge
Outpatient laboratory	No charge
Outpatient administered drugs	No charge
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	$100 per admission

Artificial insemination

Description of Artificial Insemination Services	Copayment / Coinsurance
Office visits	$15 per visit
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	$15 per procedure
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	$15 per procedure
Outpatient imaging	No charge

Description of Artificial Insemination Services	Copayment / Coinsurance
Outpatient laboratory	No charge
Outpatient administered drugs	No charge
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	$100 per admission

Assisted reproductive technology ("ART") Services

Description of ART Services	Copayment / Coinsurance
Assisted reproductive technology ("ART") Services such as invitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), or zygote intrafallopian transfer ("ZIFT")	Not covered

HRA Information

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**

Claim Form

(Instructions on next page)

navia benefit solutions

Employee Information

Last Name, First Name		SSN / Employee ID #
Home Address (Street, City, State, Zip Code)	☐ Please update my address on file	Phone Number
Employer Name		Email Address

Did you know you can submit paperless claims online or via the MyNavia mobile app? Just take a picture and submit!

HRA

Service Date(s)	Type of Service	Provider's Name	Services For Whom	Net Cost
			Total Reimbursement Request $ _____	

Signature

To the best of my knowledge my statements on this claim form are complete and true. I understand that I am solely responsible for the sufficiency, accuracy, and veracity of claims and all information related to these claims submitted to my HRA, and that unless an expense for which payment or reimbursement is claimed is a proper expense under the HRA, I may be liable for the payment of all related taxes including federal, state or city income tax on amounts paid from the HRA which relate to such expense. I further understand that no day care tax credit is permitted for amounts for which reimbursement is made. I am claiming health care reimbursement for eligible medical care expenses incurred by myself, spouse and/or dependents. Note: The IRS does not recognize Domestic Partners for purposes of receiving tax-favored health benefits. For further information, please contact your employer. I certify that these expenses have not been reimbursed under this plan or by any other source and that they will not be reimbursed by any other source or insurance. By providing an email address, I consent to receive all possible communications from Navia Benefit Solutions, agents, and subcontractors regarding the Plan via email. I may withdraw consent at any time without charge by contacting Navia by phone, email, or mail. To update your email address contact Navia Benefit Solutions by phone, email, or mail. You have the right to receive paper version of an electronic document free of charge. Software requirements will be provided with each electronic document. I hereby authorize my HRA to be reduced by the amount(s) shown above.

Participant's Signature	
X_____	Date_____

Claim Form Instructions

1. Complete employee information section. Be sure to write legibly to ensure proper processing.
2. Itemize your expenses in the table provided and attach copies of your documentation.

   Documentation must clearly show the date of service, type of service, and final cost of service. Examples of acceptable documentation include itemized bills/invoices, or the Explanation of Benefits (EOB) from your insurance carrier.

   - ❖ If your employer offers an HRA and you are enrolled in a plan that only offers reimbursement for deductible, coinsurance, and/or copays an EOB is required for claim submission.

   Proof of payment is not required in order to reimburse medical/dental/vision services.
3. Be sure to sign the claim form and submit! Please fax, email or mail a signed claim form, but choose one method only.

Submit to:

Email: 105@naviabenefits.com
Fax: Local (425) 709-7125 or Toll-free (866) 831-6222
Mail: Navia Benefit Solutions
PO Box 53250 Bellevue, WA 98015
Phone: Local (425) 452-3421 or Toll-free (866) 897-1996

Claims status is available online. Please allow at least two (2) full business days for Navia to process your claim.

REV 8/5/2022

Short-Term Disability

Short Term Disability Plan

If a participant becomes Disabled, the Plan offers a Short-Term Disability Benefit. The Participant must contact UAS (Teresa Dickerson (408) 288-4507) and request an application. **Please note the following:**

- If you are filing for Short-Term Disability your **must, NOT be on the out of work list.**
- There is a **30-day waiting period** before your Short-Term Disability may begin.
- After your 30-day waiting period, the participant will receive $1,000.00 per month for a maximum of 12 months. In addition, you will receive 12 months (maximum) of free health coverage (this means your hour bank will freeze, and you will receive free eligibility while you are disabled).
- If a participant is terminally ill, your health coverage will be extended for an additional 3 months only.
- Please be advised, the Plan does not provide a Long-Term Disability benefit. If a participant is still Disabled after 12 months, you will receive a notification from UAS requesting if you have obtained a Social Security Disability Award. If you have, you will be eligible to apply for your Pension benefits under the Plan. If the participant does not have a Social Security Award there are no other benefits available under the Plan and your reserve bank will be used up until you go onto COBRA to continue benefits. Once on COBRA, participants can pay up to 29 months of coverage, instead of the normal 18 months.

DISABILITY CLAIM NOTICE

ELECTRICAL WORKERS SAN MATEO COUNTY DISABILITY BENEFIT TRUST FUND
UNITED ADMINISTRATIVE SERVICES, P.O. BOX 5057, SAN JOSE, CA 95150-5057

Please answer all questions fully. This will help avoid unnecessary correspondence.

PART I, CLAIMANT'S STATEMENT

(1) Name of Claimant (Please Print) SOC. SEC. _____

_____ Date of Birth _____ Telephone _____

(Last) (First) (Middle Initial) Marital Status

(2) Home Address _____ ❑ Single

(No. and Street) (City) (State) (Zip) ❑ Married ___/___/___/___/___/___

(3) Employed by _____ IBEW Local No. _____

(4) Did disability arise out of your employment? ❑ Yes ❑ No ❑ Foreman ❑ Journeyman ❑ Apprentice

(5) If an accident was involved, when did it happen? Date _____ 20 _____

(a) Where did the accident occur? _____

(b) Give brief description of accident: _____

(6) Date of beginning covered employment in the electrical industry (Local 6,595,617) _____ 20 _____

(7) Date disability began _____ 20 _____ Last day actively at work _____ 20 _____

(8) Date returned to work _____ 20 _____

(9) Are you receiving or are you entitled to receive benefits from any of the following sources because of this disability or period of absence? (Each question must be answered)

Worker's Compensation	❑ Yes ❑ No	Your own or any other disability		Any Federal, State or	
Social Security	❑ Yes ❑ No	Income Plan	❑ Yes ❑ No	Provincial Agency	❑ Yes ❑ No
State Disability Insurance	❑ Yes ❑ No	Railroad Retirement Act	❑ Yes ❑ No	Other Source	❑ Yes ❑ No

If "Yes," give source of such benefits, amount of benefits and frequency of payment (weekly, monthly or lump sum) _____

_____

_____

APPLICANT: Please read carefully as the following makes you liable for payments made to you in excess of those authorized by the Plan

BENEFITS IMPROPERLY PAID: Any benefit paid to a person not entitled thereto shall be owed by him to the Trust. Notwithstanding any other provision of this Trust, over-payments shall be deducted from future benefits payable to the recipient unless the Administrative Committee concludes that requiring such repayment would be inequitable under the circumstances of the case. I further agree that, if I do not make such restitution and the Disability Trust institutes legal action to collect any sums owed to it, I will be liable to the Trust not only for such sums, but also for all costs and expenses, including reasonable attorneys' fees.

I hereby agree that, in the event it is later determined that I received more Disability Benefits than I was entitled to, I will, upon demand by the Electrical Workers San Mateo County Disability Benefits Trust, make restitution in the amount of any such over-payment. I will disclose any retroactive or lump sum payments made of the above or related benefits.

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief, true, correct and complete. I hereby authorize any physician, or any hospital, to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original. The Trust at its own expense shall have the right and opportunity to examine the person when and as often as it may require during the pendency of a claim hereunder.

Please note that to qualify for the Disability Benefits, you CANNOT be registered on the IBEW Local 617 out of work list.

Benefits will stop with the month that any beneficiary accepts a benefit payment from ANY electrical industry Retirement Plan (e.g., NEBF, IBEW, or the San Mateo County Electrical Industry Retirement Trust). Benefit payments will also stop with the first month that a beneficiary starts to receive regular Social Security benefits, (not Social Security Disability benefits).

Date this Claim Signed _____ Employee's Signature _____

Revised 12/17

ELECTRICAL WORKERS SAN MATEO COUNTY
DISABILITY BENEFITS TRUST FUND

Give to physician who first attended you when disability started

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Name of Patient _____ SSN: _____

Present Address _____

Signature of Patient _____ Date _____

ATTENDING PHYSICIAN'S STATEMENT

To be furnished without expense to the Trust:

When did symptoms first appear or accident happen?	Month	Day 20
Date patient ceased work because of disability	Month	Day 20
Date patient was first seen in emergency	Month	Day 20
Date of first attending visit	Month	Day 20
Date of last attending visit	Month	Day 20
How long will patient be continuously totally disabled and unable to work at his trade? (See Job Description below.)	From ❑ Indefinite	Thru _____ (Approximate Date) ❑ Permanently

Diagnosis and Physician's Remarks:

JOB DESCRIPTION

The following job description for Inside Wiremen can be used as a criterion for medical evaluation and analysis of a claimant's disability:

To be an Electrical Industry Inside Wireman requires physical stamina and mental aptitude. Good vision, mechanical ability and finger dexterity are essential. The trade requires climbing, crawling, crouching and working in cramped quarters, carrying loads up to 50 pounds, and the ability to pull wire up to 50 pounds.

Date _____ _____

Physician's Signature

Q&A