CAL NECA HEALTH PLAN

SUMMARY PLAN DESCRIPTION

National Electrical Contractors Association

OCTOBER 2017

Keep this Summary Plan Description and Plan Document
For Future Reference

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Dear Participant:

This booklet known as a Summary Plan Description contains general information regarding your Insurance Benefits and an explanation of the eligibility provisions. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. More information is available at www.calneca.com. Please direct any questions to the Trust Office at (408) 288-4400.

For Plan administration and service inquiries for existing members, please contact United Administrative Services as follows. For inquiries regarding program information and new membership, please contact the plan consultant, Innovative Cost Management Services.

SERVICE INQUIRIES	PROGRAM QUESTIONS
United Administrative Services 6800 Santa Theresa Boulevard, Suite 100 San Jose, CA 95119	Innovative Cost Management Services, Inc. 95 south Market Street, Suite 600 San Jose, CA 95113
408.288.4400 phone 408.288.4439 FAX calnecainfo@uastpa.com	888.244.4491 phone 4083244.3721 FAX calnecainfo@icmsbenefits.com

Please remember that this booklet is only a summary of your benefits. **In the event of any dispute, the official language of the group insurance policy or HMO will prevail; however, this booklet serves as the plan document for eligibility and other non-benefit provisions.**

For details on your benefit coverage, please refer to the Providers' Evidence of Coverage. These documents are the binding documents between the Insurance Plan and its participants. You should review the booklets and other documents furnished by the entities providing benefits for the Plan.

The Board has the discretionary authority to decide all questions about the Plan, including questions about your eligibility for benefits, and the interpretation of the Plan. No individual Trustee, Employer, or Union Representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board unless the Board gives that authority. The Board also has discretion to make any factual determinations concerning your claim. The provider retains the authority to interpret its Evidence of Coverage document and other internal documents.

In most years Open Enrollment is held annually from November 5th through December 5th, for the purposes of enrolling your dependents that were not previously enrolled when you first qualified for coverage (or within 30 days of their becoming an eligible dependent) and to change your benefit plan options selection by completing a new enrollment card through the Administration Office. Your change(s) must be received by the Administration Office by December 5th and will be effective January 1st of the new year (or the dates used in the notices in a year).

Provider benefit booklets are available at the Administration Office.

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FUTURE PLAN AMENDMENTS

Future amendments to the Plan may be made to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Trustees. You will be notified if there are important amendments to the Plan through written notification. Before you decide to retire, you may want to contact the Plan Office to determine if there have been Plan amendments or other developments that may affect your retirement plan options.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS

This booklet provides a brief, general summary of the Plan rules and is also the Plan document. You should review the Plan to fully determine your rights. **You are not entitled to rely upon oral statements of Employees of the Plan Office, a Trustee, an Employer, any Union representative, or any other person or entity.**

As a courtesy to you, the Plan Office may respond orally to questions; however, oral information and answers are not binding upon the Plan and cannot be relied upon in any dispute concerning your benefits. If you would like an interpretation of the Plan, you should address your request in writing to the Board of Trustees at the Plan Office. To make their decision, the Trustees must be provided with full and accurate information concerning your situation. You should also ensure that you provide accurate facts in all forms and documents submitted to ensure you are not held liable for coverage of ineligible Dependents and/or claims.

You should further understand that, from time to time, there may be an error in a payment or on other matters which may be corrected upon audit or review. **The Board of Trustees reserves the right to make corrections whenever any error or overpayment is discovered**.

NO GUARANTEE OF PROVIDER

The continued participation of any one physician, hospital, or other provider cannot be guaranteed. The fact that a physician or provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it medically necessary or guarantee that it is a covered service.

NO VESTED RIGHTS

Benefits under this Plan are NOT vested. The Board of Trustees may amend, reduce, eliminate or otherwise change the Plan at any time and may change, reduce, or discontinue any Plan benefits, in whole or in part, at any time. Moreover, the Board of Trustees may require new or greater co-payments at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.

ALERT: ONE YEAR PERIOD TO FILE A LAWSUIT

If an appeal has been denied or there has been a different form of adverse action taken, such person (Participant, Beneficiary or any other person or entity) has one year from the date of such denied appeal or adverse action to file a lawsuit against the Plan, an individual Trustee, the Board of Trustees and/or any other person or entity involved with the denied appeal or adverse action. If the person fails to do so, no lawsuit is permitted. This one-year limitation period covers any and all claims for benefits referenced in this Plan and is intended to supersede any language in this Plan document to the contrary.

I. GENERAL – RESTATED PLAN

A. ESTABLISHMENT OF PLAN.

1. **Restatement of Plan:** The Board of Trustees restates the CAL NECA Health Plan as of January 1, 2017. The Plan's medical benefits are offered through Blue Shield or through a health maintenance organization, which is Kaiser Permanente (HMO) (hereafter "Kaiser"). Other benefits are provided as listed in section 6 on the next page of this booklet. The provisions of this Plan are effective as of January 1, 2017, although certain provisions have different effective dates as noted. Current information on the Plan can be found at www.CALNECA.com.

The Plan is intended to be maintained for the exclusive benefit of Participants and their eligible Dependents. It is also intended that this Plan Document shall conform to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA), as that Act applies to multiemployer health and welfare employee benefit plans such as the Plan.

2. **Election of Health Maintenance Organization (HMO) Benefit Option:** The Board of Trustees provides the option to elect enrollment by the eligible Participant and his or her eligible Dependents in one or more Health Maintenance Organizations (HMO). Currently, the Plan offers HMO and PPO benefits through Blue Shield and HMO benefits through Kaiser.

An HMO uses a group of doctors and other health care professionals who emphasize preventive care and early intervention. HMO services are prepaid and a designated premium covers services. You share some costs, however, by paying a fee called a co-payment for some services and products.

To be eligible to enroll in an HMO, you must live within the HMO's service area. Moreover, services may not be covered unless preauthorized by your Primary Care Physician (PCP). For medical services to be covered you must follow the HMO procedures and you must use an HMO network provider. You are required to include a residence address (rather than a P.O. Box) when you complete your Enrollment Form. If you move out of the geographic area of the HMO, you may be required to change your coverage under the Plan. You and your family members are required to have the same coverage selection (for example, one family member cannot select Kaiser and the other Blue Shield). The times and the geographic areas in which such enrollment may be open to Plan Participants will be determined by agreement between the Board of Trustees and the HMO.

3. **Preferred Provider Organization (PPO) Benefit Option:** Currently, the Plan also offers PPO benefits through the Blue Shield Plan. The PPO option allows you to receive care from any of the doctors, other health care professionals, and hospitals within the plan's network, as well as outside of the network for covered services. Unlike the HMO option, the advantage of choosing the PPO option includes the flexibility of seeking care with an out-of-network provider (subject to higher deductible and/or coinsurance) and the ability to visit any specialist without obtaining a referral from your primary physician.

You will have a yearly deductible (e.g., $100 individual) to meet before the Plan starts paying your medical costs. After that, some services you receive may be 100% covered or you may have to pay a coinsurance (e.g., 10%) which is your share of costs calculated as a percentage of the allowed amount for your covered service.

4. **Incorporation of HMO as Part of Plan:** At any time or times that the Board of Trustees enter into a new or different contract and/or renewal contract with an HMO, such contract(s) is incorporated in this Plan effective as of the date of such contract, provided same has been executed by the Board of Trustees or a duly authorized representative of the Board of Trustees.

5. **Consequences of Election of HMO Plan by Participant:**

a. Benefits Not Part of HMO. Benefits payable to an Employee, Participant and/or eligible Dependent(s) who has elected enrollment in an HMO shall be determined solely in accordance with the contract between the Trustees and the HMO except for Life Insurance and Accidental Death and Dismemberment (through an Insurance Company) (Actives only).

b. HMO Rules Apply. All rules and/or regulations set forth herein regarding claims review and/or appeals, shall be governed by the rules and regulations of the HMO without regard to similar rules and regulations that may be otherwise set forth in this Plan.

6. **Additional Benefits:** The Plan provides the following types of additional benefits subject to certain eligibility provisions and exclusions to eligible Participants and their Dependent(s):

a. Life Insurance and Death Benefit (through Blue Shield of California)
b. Dental Care (through Delta Dental)
c. Orthodontic (through Delta Dental)
d. Vision Care (through VSP)

HMO and Carrier Rules Apply. All rules and/or regulations set forth herein regarding claims review and/or appeals, shall be governed by the rules and regulations of the HMO and Carrier without regard to similar rules and regulations that may be otherwise set forth in this Plan.

B. PLAN MAY BE CHANGED.

The Board of Trustees of the Plan expressly reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time. Benefits provided under this Plan are NOT vested. The Board of Trustees expressly reserves the right, in its sole discretion, to:

1. Terminate or amend either the amount or condition with respect to any benefit, even though such termination or amendment affects claims which have already accrued; and
2. Alter or postpone the method of payment of any benefit; and
3. Amend, terminate or rescind any provision of the Plan; and
4. Merge the Plan with other plans, including the transfer of assets; and
5. Terminate any HMO or insurance company; and

6. Restrict coverage to those living only in certain geographic areas.

The authority to make any changes to the Plan rests solely with the Board of Trustees.

C. PLAN AND OPERATION.

1. Board of Trustees Responsibilities: The Plan is administered by a Board of Trustees comprised of Trustees appointed by the different California NECA Chapters. The current Trustees are listed on page iii of this booklet.

The Trustees have many powers and functions including investing the Plan's assets, interpreting Plan provisions, amending the Plan, answering policy questions, and contracting with advisors and consultants, such as an auditor, legal counsel, and investment manager.

Only the Board of Trustees and its authorized representatives are authorized to interpret the Plan's benefits described in this booklet. No one else can interpret this Plan or act as an agent for the Board of Trustees -- this includes Employers, NECA and their representatives. The Board of Trustees (and persons or entities appointed or so designated by the Board of Trustees) has the full discretionary authority to determine eligibility for benefits and to construe the terms of the Plan (and other documents pertaining to the Plan and Trust) and any rules adopted by the Board of Trustees.

The Board of Trustees of the Plan is the named fiduciary with the authority to control and manage the operation and Plan of the Plan. The Board shall make such rules, interpretations and computations and take such other actions to administer the Plan as the Board, in its sole discretion, may deem appropriate. The rules, interpretations, computations and actions of the Board are binding and conclusive on all persons.

2. Standards of Interpretation: The Board of Trustees, and/or persons appointed by the Board, shall have the full discretionary authority to determine eligibility for benefits and to construe the terms of this Plan and any regulations and rules adopted by the Board. Only the Fund Manager and/or the Board of Trustees acting upon appeals properly before the Trustees shall have the authority to bind the Trustees to an interpretation of the provisions of this Plan. Nonetheless, claims and appeals for matters relating to an HMO are subject to that HMO's rules and procedures.

3. Delegation of Duties and Responsibilities: The Board of Trustees may engage such employees, accountants, actuaries, consultants, attorneys and other professionals or other persons to render advice and/or to perform services regarding any of its responsibilities under the Plan, as the Board shall determine to be necessary or appropriate.

4. Availability of Fund Resources: Benefits provided through the Plan Office can be paid only to the extent that the Plan has adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder, beyond the obligation to make contributions as provided in the Collective Bargaining Agreement. If at any time the Plan does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any Contributing

Employer to make benefit payments or contributions (other than the contributions for which the Contributing Employer may be obligated by a Collective Bargaining Agreement) to provide for the benefits established hereunder. There shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, the Union, Signatory Associations or other person or entity to provide benefits established hereunder if the Plan does not have sufficient assets to make such benefit payments.

5. Funding Methods and Benefits: The Board of Trustees may provide benefits either by insurance or HMO or by any other lawful means or methods upon which they may determine. The coverage to be provided shall be determined in the sole discretion of the Board of Trustees and limited to such benefits as can be purchased with the funds available.

6. Special Exclusion for Fraud/Reimbursement or Offset for Overpayment: No benefits will be paid for fraudulent claims of services or supplies made by a Participant, eligible Dependent, or any other person. If a fraudulent claim has been paid on behalf of any person, both the Participant and any person on whose behalf a fraudulent claim was submitted will be liable to the Plan for repayment. This includes for any other reasons (including, but not limited to enrolling an ineligible dependent under the Plan, failing to notify the Plan that a previously eligible dependent no longer qualifies as a dependent, or failure to timely enroll in Medicare). The Participant and person on whose behalf a fraudulent claim was submitted will also be responsible for any attorney's fees and costs incurred by the Plan as a result of the fraudulent acts.

If a Participant or any eligible Dependent of the Participant has any outstanding liability due to fraudulently paid claims, neither the Participant nor any eligible Dependents may assign any rights to benefits to a provider of service until all fraudulently paid benefits have been repaid in full. If fraudulently paid benefits are not repaid in full, any purported assignment of benefits by a Participant or eligible Dependent may be disregarded by the Plan. However, if any payment of benefits is made by the Plan under a purported assignment, this would not be a waiver of the right of the Plan to refuse to acknowledge other purported assignments.

If any fraudulent claims have not been repaid when a Participant or eligible Dependent incurs covered charges, the Participant or eligible Dependent shall pay all charges directly and file a claim for credit in lieu of benefits, until the entire amount of the fraudulent claims have been credited. The Plan may offset any amounts owed against any benefits that may be payable under the Plan for a Participant and/or his Dependents

In addition, any Participant or eligible Dependent who owes money to the Plan may be required to sign a written agreement before a notary agreeing to have any owed amounts deducted, offset, or paid from any death benefit, benefits payable from a life insurance company with which the Plan has a contract, or payment from any distribution from the Retirement Plan.

7. Plan Year: The Plan Year starts on **January 1** of each year and ends on **December 31**.

8. Grandfathered Plan: The Board of Trustees believes this Plan is a "Grandfathered health plan" under the federal law known as the Patient Protection and Affordable Care Act ("ACA"). As permitted by the ACA, a Grandfathered health plan can preserve certain basic

health coverage that was already in effect when that law was enacted. Being a Grandfathered health plan means that the Plan may not 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. However, Grandfathered health plans must comply with certain other consumer protections in the ACA, such as the elimination of annual and lifetime limits on the Plan's 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 Fund Manager at the number listed on page v. 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. Implementation of the Act's provisions began with the January 1, 2011 Plan Year.

D. YOUR RESPONSIBILITIES.

1. Your Mailing Address: It is your responsibility to keep the Plan Office advised of changes to your address so that you may continue to receive notices of important Plan changes that may affect your coverage or continue to receive Plan information. Changes must be made in writing by completing the appropriate Enrollment Form or Change of Address Form, both of which are available on the Plan's web page for the Plan at https://www.ibew617benefits.com. Please note: neither Kaiser nor Blue Cross will accept a PO Box address as a mailing address or place of residence. All Plan Participants must provide a street address to enroll in either health plan.

2. Enrollment Form: Full completion and return of the Enrollment Form is mandatory for all Plan Participants for enrollment, changes and upon request by the Plan Office. You are required to complete a new Enrollment Form and submit to the Plan required proof when you have a change in life circumstances (such as a marriage, separation, divorce, birth of child, Dependent status changes, Medicare eligibility or QMCSO). In addition, neither Kaiser nor Blue Cross will accept a PO Box address as a mailing address or place of residence. All Plan Participants must provide a street address to enroll in either Health Plan. Generally, any changes will be effective the first day of the following month after your updated Enrollment Form is received.

II. ELIGIBILITY RULES

A. General

Your employer will provide you with information regarding coverage options at the time you become eligible for coverage. Options and eligibility dates may vary depending upon your employer. Some employers offer only one option while others may offer multiple options. This applies to the number of HMO options and whether dental or vision coverage is available.

B. Eligible Employer

1. **NECA MEMBER CONTRACTORS:** Contractors who are members in good standing of the National Electrical Contractors Association (NECA), whose principal business is within the geographical area of District Nine of NECA (California/Nevada) and who sign a participation/subscription agreement;

2. **NECA CHAPTERS**: NECA Chapters in the geographical jurisdiction of District Nine that sign a participation/subscription agreement; and

3. **INDUSTRY RELATED GROUPS:** Other industry related organizations sponsored by NECA chapter and approved by the Board of Trustees that sign a participation/subscription agreement.

C. Eligible Employee

Permanent full-time employees of an Eligible Employer are eligible employees. A full-time Eligible Employee must perform work 30 or more hours per week for the Eligible Employer and not be a member of a collective bargaining unit. All such employees must be enrolled in the Plan.

An employee who is a covered dependent under a spouse's health care plan may be excluded from the classification of "permanent full-time employee" if he signs a waiver of coverage acknowledging that he can only become covered under a plan sponsored by the Trust at open enrollment. The Plan will provide the "waiver of coverage" form.

D. Initial Eligibility

Initial eligibility is established by your employer. Coverage may be immediate or there may be a waiting period for as long as ninety (90) days from your date of hire. Check with your employer to determine the eligibility date.

E. Premium Payments

Your employer must submit premium payments monthly for continued eligibility. Premium payments are due by the 15th of the month prior to the month of coverage. As an example, payment on January 15th provides coverage for the month of February. **You lose coverage if your Employer fails to contribute on your behalf.**

F. Covered Dependents

Your Covered Dependents are your lawful spouse (husband or wife including same sex spouses) if not legally separated from the employee, natural children, legally adopted children and stepchildren. California law and this Plan do not recognize so-called common law marriages.

1. Effective Date: A dependent's coverage will become effective on the later of:

a. the date you become eligible or your dependent becomes eligible for Dependent Coverage or

b. the date your dependent becomes an eligible dependent, (due to marriage, birth adoption), provided the required dependent contribution is timely received. You must complete an application to add any new dependent.

2. Dependent Rules. Dependent Children includes (through age 25):

a. Blood Descendent: A blood descendent of the first degree;

b. Adopted Child: A legally adopted child, including children living with adopting parents during the period of probation and children for whom the adopting parents have assumed and retained a legal obligation to provide total or partial support in anticipation of adoption;

c. Stepchild: A stepchild residing in the employee's household; and

d. Related Child or Children: A child residing permanently with the employee, who is head of the household, and who is being solely supported by the employee. Except for children who have been or are being adopted by the employee, the child must be related by blood or marriage to the employee, or the employee must be the child's legal guardian;

e. Adding Dependents: During the period you continue to have coverage, any new eligible dependents you acquire may be added in accordance with the dependent's eligibility provisions, and any eligible dependents you decline to insure before your continued health coverage began may be added during any open enrollment period provided by the plan. Coverage will be immediate for all dependents without any preexisting condition limitations;

CHANGES IN DEPENDENT STATUS – NOTIFY THE PLAN

It is the Participant's and/or Dependent's responsibility to notify the Plan Office immediately when a Dependent's status changes. This includes a Spouse or other Dependent no longer residing with the Participant, divorce/final dissolution of marriage, legal separation, a Dependent child over 25 and any other events which would no longer make your dependent eligible for coverage. If claims are paid for, or premiums are paid on behalf of any Dependent Spouse or child and it is later found that the Dependent was not eligible, **you and the Dependent will be responsible for reimbursing the Plan for the actual amount paid out in benefits by the Trust plus interest and any costs and attorney's fees.**

f. Age Limit for Children: Children are eligible for all benefits provided from birth through the end of the month in which the child attains age 26.

Plan reserves the right to periodically request supporting documentation or written verification that an enrolled Dependent continues to meet Plan Dependent requirements (i.e. written confirmation and/or documentation that a spouse still resides with you etc.).

IMPORTANT NOTICE:
WARNING ABOUT FRAUD AGAINST PLAN

It is both the Participant's and Dependent's responsibility to notify the Plan Office immediately when the status of a Spouse, Child or other Dependent changes. This includes divorce/final dissolution of marriage, legal separation, death, a child attaining age 26 and any other events which would make your dependent not eligible for future coverage. If claims are paid for, or premiums are paid on behalf of any Spouse (or former spouse), child or other Dependent and it is later found that the individual was not eligible, you and the Dependent will be responsible for reimbursing the Plan for the amounts paid plus interest and any costs and attorney's fees incurred to recover the money.

6. Domestic Partners: A Domestic Partner will be covered provided the domestic partnership meets the following:

1. Both persons must file a Declaration of the Domestic Partnership with the Secretary of the State of California and provide a copy to the Plan Office;[1]

2. Both persons must have a common residence;

3. Neither person may be married to someone else or be a member of another domestic partnership with someone else that has not been terminated, dissolved or adjudged a nullity;

4. The two persons must not be related by blood in any way that would prevent them from being married to each other;

5. Both persons are at least 18 years old;

6. Both persons must be members of the same sex, or, if opposite sex, one or more persons must be over age 62; and
7. Both persons must be capable of consenting to the domestic partnership.

For Non-California Domestic Partnerships, you will be required to register such Domestic Partnership with the State of California and must meet the requirements above to be eligible for coverage under the Plan.

Domestic Partner No Longer Qualifies. In addition to the above requirements, both the Covered Participant and the Domestic Partner agree to inform the Plan Office of the termination of their domestic partnership because of a change in one or more of the above requirements or the death of the domestic partner. It is the Participant's responsibility to notify the Fund Office once a Domestic Partner no longer meets the Plan's Domestic Partner eligibility requirements. A

[1] For those Participants who do not live in the State of California and are, therefore, not eligible to file a Declaration of Domestic Partnership with the Secretary of State's Office, the Fund will accept a properly completed Affidavit of Domestic Partnership as proof of the domestic partnership so long as the criteria set forth in 2-7 above is met. The Plan Office will provide Participants with the Affidavit upon request.

Participant who fails to notify the Fund Office within 30 days of the date that a Domestic Partner has a change in eligibility status will be legally responsible for any payments or premiums made by the Plan from the date the Domestic Partner became ineligible for coverage. Eligibility of a Domestic Partner shall terminate on the date the Domestic Partner no longer meets the Plan's eligibility requirements including lack of timely payment of the imputed income taxes.

Imputed Income. The election by a Covered Participant to add a domestic partner may have certain Federal income tax implications. Under Federal tax law, the fair market value of health coverage provided to a domestic partner is a taxable benefit to the Participant. (Please note that domestic partner benefits are not taxable under California law.) Each year the Fund will calculate the fair market value of the domestic partner coverage and this information will be sent to participating employers. The Participant's employer is then responsible for including the imputed income on the Participant's wages and withholding any FICA, FUTA, Medicare and Federal income taxes as applicable.

Proof of Continuing Eligibility. The Plan may require evidence of continued domestic partnership status at any time.

7. Automatic Coverage for a Newborn Child- If Plan Notified Within 30 Days: A newborn or newly adopted child will automatically be covered for the first 30 days of medical benefits on the date the child becomes a Dependent. However, you are required to apply for Dependent coverage for that child within 30 days of the child's birth or of the adopted child's placement in your home to continue that child's coverage beyond the first 30 days. You are urged, however, to enroll the new child immediately. **If you fail to do so, there is no coverage, and you MUST WAIT UNTIL THE NEXT ANNUAL OPEN ENROLLMENT PERIOD TO ENROLL THE CHILD.**

If you are required to contribute toward the cost of insurance and if the child's coverage terminates because you fail to apply (or pay the required contribution) within the 31-day period, no benefits will be payable. The Individual Purchase Rights and the extended Benefits (after termination of coverage) will not apply to the child.

8. Qualified Medical Child Support Orders (QMSCO) (including National Medical Support Notice):

The Participant must timely provide the Plan Office with a copy of any court order that establishes the Participant's legal obligation to maintain coverage on a Dependent Child (known as an "alternate recipient"). The Plan will recognize a Qualified Medical Child Support Order ("QMCSO"), including a properly completed National Medical Support Notice ("NMSN") that meets the requirements of the Employee Retirement Income Security Act ("ERISA"). In general, a QMCSO recognizes an eligible child's right to receive Plan benefits as a beneficiary of an eligible Plan Participant. The child, to be covered for benefits by this Plan, must meet Plan requirements for an eligible Dependent child including age requirements (under Age 26).

Please be aware that if a child covered under a QMCSO and/or NMSN was enrolled independent of the Participant neither the Participant nor any other Dependents would be considered enrolled in the Plan until the Participant has completed all Enrollment Procedures. In addition, the

Participant and any other eligible Dependents would then be limited to enrollment into only that Health Plan option that the child covered under the QMCSO and/or NMSN has been enrolled in.

9. Family Medical Leave Act (FMLA) Continuation of Health Coverage: If your Employer has at least 50 Employees, your Employer may be required to continue to pay for your health coverage on the same terms as if you had continued work, during any approved leave under the Federal Family and Medical Leave Act of 1993 (FMLA). In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

(1) You worked for the Employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and

(2) You require leave for one of the following reasons:

(i) Birth of a child and to care for the newborn child within one year of birth;
(ii) Placement of a child for adoption of foster care and to care for the newly placed child within one year of placement;
(ii) Care for your child, spouse or parent with a serious medical condition;
(iii) Your own serious health condition that makes you unable to perform the essential functions of your job;
(iv) Military Caregiver Leave (up to twenty-six (26) weeks during a 12-month period). Care for your spouse, son, daughter, parent, or next of kin who is a member of the Armed Forces (including the National Guard or Reserves), and undergoing medical treatment, recuperation, or therapy for a serious injury or illness; or
(v) Any other purpose provided for by the FMLA.

Coverage will not be continued beyond the earlier of:

- Date contributions are not timely made;
- Date your Employer determines your approved FMLA leave is terminated; or
- Date your coverage involved discontinues as to your eligible class.

Details concerning FMLA leave are available from your Employer. If your Employer grants you an approved FMLA leave in accordance with FMLA, you may continue health coverage for you and your eligible dependents provided your Employer maintains the required contributions to the Plan on your behalf or you make any required contributions to the Plan. Requests for FMLA leave must be directed to your Employer. The Plan Office cannot determine whether you qualify.

If your coverage terminates because your approved FMLA leave is deemed terminated by your Employer or you fail to return to work after exhausting your FMLA leave, you may, on the date of such termination, be eligible for COBRA continuation coverage under Federal law, on the same terms as though your employment terminated, other than for gross misconduct, on such date. If a dispute arises between you and your Employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments. If the dispute is resolved in your favor, and your Employer makes the required contributions, the Plan may refund the corresponding COBRA payments to you.

NOTE: If your Employer continues your coverage during an FMLA leave and you fail to return to work, you may be required to repay the Employer for all contributions paid to the Plan for your coverage during the leave.

It is the responsibility of your Employer (not the Plan) to notify you of your rights under FMLA and to approve your request for FMLA leave. It will be your responsibility to notify your Employer that FMLA leave is being taken.

G. SPECIAL ENROLLMENT RIGHTS.

Other than during Open Enrollment, the Plan is required to provide Special Enrollment Rights to you and your eligible Dependents upon the following events:

1. Loss of Other Coverage: If you did not enroll yourself and/or your eligible Dependents because you and/or your Dependents had other group health coverage or other health insurance, including COBRA continuation coverage, and showed the Plan Office evidence of such other coverage, you and/or your eligible Dependents may enroll in this Plan during a Special Enrollment period. This Special Enrollment period is a 30-day period which begins when you lose the other coverage. To take advantage of this Special Enrollment Right, you and/or your Dependents must enroll in the Plan within 30 days of exhausting COBRA continuation coverage or the termination of such other coverage as a result of a loss of eligibility for coverage (such as a divorce, legal separation, death, termination of employment, reduction in the number of hours, ceasing to reside, live or work in the HMO service area if no other coverage is available under the other plan, or dependent ceasing to qualify as a dependent under the other plan).

2. Acquire New Dependents: Newly acquired eligible Dependents, including your legal spouse, newborn, adopted child(ren) or step child(ren), will be covered from the time of birth, adoption, placement for adoption, or marriage provided you complete and submit an Enrollment Form and appropriate documentation to the Plan Office within 30 days of the birth, adoption, placement for adoption, or marriage.

3. Special Enrollment Allowed Under The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP): The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) created a special enrollment period that applies to group health plans, similar to those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes. Under this Act, group health plans must permit yourself and/or your eligible dependents with group health plan coverage to enroll in the Plan if they:

- Lose eligibility for Medicaid or CHIP coverage; or
- Become eligible to participate in a premium assistance program under Medicaid or CHIP

In both cases you and/or your eligible dependent must request special enrollment within 60 days (of the loss of Medicaid/CHIP or gaining eligibility for premium assistance under Medicaid or CHIP, as applicable. More information is available at *www.coveredca.net* or *www.dhcs.ca.gov/services/medi-cal*.

H. HEALTH REIMBURSEMENT ACCOUNTS

1. Allocate Earnings or Losses/Statements

HRA Accounts that have a year-end balance may be credited (or charged) an amount reflecting the income (or loss) on those Accounts for the Plan Year, at the discretion of the Board of Trustees. Regardless of whether income or losses are allocated to HRA Accounts, the Board of Trustees reserves the right to assess an administrative charge against HRA Accounts. The Plan will provide Participants with a statement annually showing the amount in their HRA as of December 31 of each year. Such statements will be provided within a reasonable period after the end of the year. The Board of Trustees has the discretion to provide statements more often.

2. Other Plan Premiums

Any Participant may use his or her HRA Account to make Self-Payments for his or her coverage, when otherwise eligible to make Self-Payments and/or COBRA payments. A surviving spouse or surviving eligible dependent (as defined by the Internal Revenue Code) of a Participant may use the Participant's HRA Account to make monthly required payments for Plan survivor benefits, or to pay premiums for COBRA coverage based on the death of the Participant. If the eligible dependent(s)' Plan survivor coverage or COBRA continuation coverage period ends before the Participant's HRA Account is exhausted, that Account may be used to pay for the extended coverage for the Participant's dependent(s), at the COBRA continuation coverage rate, until the earlier of the following time (i) the HRA Account is exhausted; (ii) other coverage becomes available (including, but not limited to, coverage through Medicare or through another group health plan); or (iii) for a surviving child, the child attains the applicable limiting age under the plan.

3. Qualified Expenses

Any active or retired Participant who is eligible for benefits under this Plan may be reimbursed from his or her HRA account for any qualified expenses that are not otherwise covered under the Plan. To qualify for payment through a Participant's HRA Account, the expense must be a "Qualified Expense" as defined in in IRC Section 213(d). **For a complete list please view the IRS publication at *http://www.irs.gov/pub/irs-pdf/p502.pdf*.** For example, below is a list of some examples (not an all-inclusive list) of Qualified Expenses which are reimbursable if not otherwise covered by the Plan:

Abdominal Supports	***Gum Treatment***	***Acupuncture***	***Air Conditioner***
Alcoholism Treatment	***Abortion***	***Anesthetist***	***Arch Supports***
Artificial Limbs	***Ambulance***	***Blood Tests***	***Blood Transfusions***
Braces	***Birth Control Pills***	***Chiropractor***	***Childbirth/Delivery***
Diagnostic fees	***Cardiographs***	***Prescriptions***	***Eye Glasses***
Blood Tests	***Drug Addiction Therapy***	***Gynecologist***	***Vaccines***
Blood	***Oral Surgery***	***Insulin treatment***	***Wheel Chair***
	Lab Tests	***Psychiatrist***	***Splints***

Transfusions	***Pediatrician***	***Orthotic Shoes***	***Registered Nurse***
Hospital Bills	***Hydrotherapy***	***Podiatrist***	***Oxygen equipment***
Hearing Aids	***Vitamins (if prescribed)***	***Guide Dog***	***Lead paint removal***
Splints	***Christian Science practitioner***		
Dermatologist			
Dental X-Rays			

The expense must have been incurred while the Participant was covered by the Plan. An expense for premiums for medical coverage shall be reimbursable only if (i) the expense is authorized pursuant to the Plan or (ii) the Participant is on Self-Pay or COBRA or covered as a retiree, and the premium is for coverage of a dependent under insurance or a group health Plan other than this Plan.

The expense must have been incurred by the Participant or by a person who was then either a covered eligible dependent of the Participant or by a person who was a dependent within the meaning of the Internal Revenue Code Section 152.

The claim for HRA Account benefits must be made within one year of the time the expense was incurred. Extensions of this time limit will be granted only for good cause shown, at the sole discretion of the Board of Trustees.

The Participant or dependent must provide proof, satisfactory to the Board of Trustees that the claim satisfies the requirement of this Section.

4. No Vested Right to HRA Account/No Cash Death Benefits

HRA Accounts may be used for any of the purposes allowed under the Internal Revenue Code and Plan rules below, and only for such purposes. No provision in these HRA rules shall be construed as making such Accounts vested at any time or subject to use in any manner except as provided in these rules. There is no vested right to an HRA balance. Pursuant to Internal Revenue Code guidelines, no cash death benefits are permitted under the Plan.

5. Procedures for Payment of Benefits

Benefits will be paid only to a Participant or surviving eligible dependent. Benefits will be paid only after an eligible person has incurred a Qualified Expense, and timely submitted a claim with supporting documents. Assignment of HRA Account benefits is not allowed.

Benefits will be paid in the manner and time established by the Board of Trustees. If a Participant, retiree, or dependent is aggrieved by the action on a claim he or she may appeal that action to the Board of Trustees, under the Plan's general appeal procedure.

6. Forfeiture

An HRA Account shall be immediately and permanently forfeited if either of the following applies to the Participant:

The Participant accepts employment in any capacity and of any duration from a contractor in the Electrical Industry who is not signatory to the collective bargaining agreement The Participant is an owner of a company/business/entity in the Electrical Industry, which is not signatory to a collective bargaining agreement of an IBEW Local Union having jurisdiction of the work.

7. No Cash Death Benefits/Compliance with Internal Revenue Code

To the extent required by the Internal Revenue Code and/or lawful regulations cash death benefits from an HRA Account Participant's Account are not permitted. Any pertinent rule of the Internal Revenue Code and/or the IRS Regulations as applied to an HRA shall apply to this Plan. Thus, if you die without a spouse, child or other dependent, any remaining benefits in your HRA Account will remain with the Plan (pursuant to IRS rules).

8. Effect of Forfeiture

Any Participant who regains eligibility for coverage under the Plan after forfeiture of his or her HRA Account shall be allowed to accrue new credit, but will not regain the credits that were forfeited. Forfeitures shall be used to pay plan expenses and otherwise credited to the HRA Accounts of other Participants, in the same manner as earnings.

III. GENERAL LIMITATIONS – EXCLUSIONS FROM COVERAGE

The benefits summarized in this booklet do not cover any injury or sickness:

a. From, or in the course of, any work for pay or profit;

b. For which you have the right to benefits under any Workers' Compensation Law, or similar law;

c. Caused by an act of war, declared or not;

d. Self-inflicted and/or intentional injury, or an illness (unless caused by a medical condition as defined by HIPAA). This exclusion shall include an illness or injuries which were incurred as a result of the Plan Member's use of alcohol or drugs, in excess of a state or federal statute, or non-prescribed use as defined by a licensed medical examiner.

e. Charges for care, treatment, services or supplies:

i. Paid for by a federal, state or local government agency, or

ii. Provided by a hospital run by such agency; unless, by law, you or we must pay the charges.

III. SELF-PAYMENTS (Prior to COBRA)

To maintain continuous coverage, a Participant whose coverage has terminated or has insufficient hours for coverage, may elect to pay for continued coverage under one of the following two options:

A. Premium Payments

Your employer must submit premium payments monthly for continued eligibility. Premium payments are due and must be received by the 15th of the month prior to the month of coverage. As an example, payment on January 15th provides coverage for the month of February.

B. Pre-Existing Conditions

Pursuant to the Affordable Care Act, pre-existing conditions may NOT be excluded from coverage. A pre-existing condition is defined as an illness, condition or set of symptoms that originated, were diagnosed, were being treated, or had medication prescribed the immediate six months prior to enrollment under this Plan. Also included are complications and any results of treatment of any pre-existing condition.

A condition is diagnosed whenever a health care provider tell a person that he or she either has may have had that condition or makes an entry to that affect in the person's medical records. This applies even if the physician is examining or treating a person for a different condition.

In addition to the above criteria for pre-existing conditions, chemical dependency and/or mental health conditions will be considered pre-existing conditions if there was court directed care, professional treatment or recommended care, or voluntary program attendance within the immediate six months prior to the coverage effective day of this plan. Your HMO booklet will explain any pre-existing limitations.

C. Newly Acquired Dependents – 30 Days to Enroll

It is important for a participant to complete a change of enrollment form if he or she wishes to add a new spouse or newly acquired dependent children. This must be done within 30 days of individual(s) becoming the participant's dependent(s).

It is important for a participant to complete a change of enrollment form, within 30 days of birth, or in case of adoption, the date the child is placed in the participant's custody. You, as a participant, must obtain and complete a new enrollment card from the Administration Office to add additional dependents.

D. Military Service

Any eligible person who enters the military service or military training under the laws of the United States may elect to have coverage suspended. This request must be made in writing to the Board of Trustees and will be effective the first day of the month following receipt of the request. See address below.

You should notify the Administration Office in writing, as soon as you are aware that you will resume active work by sending a letter to:

United Administrative Services
6800 Santa Teresa Boulevard, Suite 100
San Jose, CA 95119

E. Uniformed Services Employment and Reemployment Rights Act (USERRA)

In accordance with the Uniformed Services Employment and Reemployment Rights Act, if you are on military leave you will retain continuation coverage rights similar to those described under COBRA. Continuation coverage will be limited to a term that ends on the earlier of 18 months or the date on which USERSRA requires you to offer to return to civilian employment. That date is determined by the following rules:

a. If the period of military service is less than 31 days you must return, and continuation coverage will end, by the beginning of the first regularly scheduled work period after the end of the last calendar day of duty. This period is extended by the time required to return home safely. If this is impossible or unreasonable, then you must return as soon as possible.

b. If the period of service is 33 to 180 days, you must return and continuation coverage will end no later than 14 days after completion of your service. If this is impossible or unreasonable through no fault of yours, then you must return as soon as possible.

c. If the period of service is 181 days or more, you must return and continuation coverage will end no later than 90 days after completion of your military service.

d. If you suffer from a service-connected injury or illness, the deadlines for returning to work are extended for up to two years while you are hospitalized or convalescing.

If you are on military leave for less than 31 days, there will be no charge to you for your medical coverage. Otherwise, you and your eligible dependents must file a timely application following the end of the initial 30-day period of military service, make monthly self-payments directly to the Administration Office, and notify the Administration Office and your employer that you are leaving work for military service.

Continuation coverage under USERRA will not terminate if you or your dependents become covered by another group health plan.

F. HMO Enrollees

If you or your spouse or dependent have USERRA continuation coverage through the Plan's HMO programs and you are terminated from the program because you move out of the HMO's service area before the applicable USERRA period expires and the Plan does not have a contract with your HMO in that area, you or your spouse or dependent will be allowed to enroll in the Group Medical Plan until the expiration of the applicable USERRA period, so long as payment of USERRA premiums are continuous and timely and the other USERRA requirements are met for the continuation of health coverage. Please call the Administration Office for additional details.

IV. COBRA CONTINUATION COVERAGE

A. ELIGIBILITY FOR COBRA.

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), requires that group health plans offer covered Employees and their Dependents the opportunity to elect to pay a temporary extension of health coverage (called "Cobra Continuation Coverage" or "COBRA") in certain instances (called "qualifying events") where coverage under the Plan would otherwise end. To receive this continuation coverage the Employee, spouse and/or Dependent(s) must make timely monthly payments (including the stub payment form) directly to the Plan (or, the Bank Depository if so designated by the Plan Office).

When you no longer have sufficient hours in your Reserve Hour Bank, your COBRA coverage will run concurrently with any continuation of coverage described in section B on page 40. **In other words, your COBRA extension period is reduced by the number of months under the Active Subsidized Self-Pay coverage.** Even if you do not elect COBRA continuation coverage, your spouse and each of your eligible dependents have a separate right to elect it. You, your spouse and your eligible Dependents should read this section of your benefit booklet.

A qualifying event is any of the following:

1. The death of the Participant;
2. The Participant's termination of employment (except for gross misconduct);
3. A reduction in the Participant's hours;
4. The divorce or legal separation of the Participant and his or her spouse; or
5. A child no longer meets the definition of a Dependent.
6. The Participant becomes entitled to Medicare.

To receive this COBRA coverage, a Participant end/or his eligible Dependents must file a timely application following the qualifying event and make monthly self-payments in an amount determined by the Board of Trustees directly to the Bank Depository (designated by the Plan Office), including the payment stub.

B. COBRA RULES.

1. COBRA Continuation Coverage: Upon payment of the required monthly premium (which is usually set at 102% of the applicable cost of medical coverage), you and/or your dependent(s) may elect COBRA continuation coverage as follows.

a. Termination of Employment or Reduction in Hours. A Participant or dependent may elect COBRA for medical benefits and prescription drug coverage only (c0er), or medical, prescription drug, dental and vision coverage (core and non0core benefits) for a period of up to 18 months if you lose your health coverage because of termination of your Covered Employment or a reduction in hours (including having used all hours in your Reserve Hour Bank), unless such termination is due to your Gross Misconduct. This 18-month period is reduced by the number of months of Active Subsidized Self-Pay.

By electing COBRA continuation coverage, you will be electing to maintain benefits on behalf of your eligible Dependents. If you do not elect COBRA continuation coverage, your spouse may independently elect such coverage on behalf of himself or herself and eligible Dependents if applicable and pay the required premium.

b. Disability-Extended Coverage for 29 Months. For an additional premium and subject to certain notice provision, an Employee or other eligible Dependent may elect continuation coverage for an additional 11 months if the Employee or eligible Dependent is determined by the Social Security Administration to be totally disabled and permanently disabled as of the date of the Employee's termination or employment or reduction in hours (i.e., the qualifying event which invoked COBRA coverage) or within sixty days of the COBRA coverage. You pay 150% of the applicable premium for the additional 11 months of coverage. To qualify for this special extended COBRA eligibility. You must report the Social Security disability determination to the Plan Office before the initial 18 months of COBRA coverage expires and within 60 days after receipt of the Social Security determination). +This disability extension ends immediately if the disabled individual recovers.

2. Thirty-Six Month COBRA Coverage for Dependents: A Dependent spouse or child who would otherwise lose health coverage is eligible for continuation coverage for up to 36 months because of the following qualifying events:

(1) The death of the Employee;
(2) Divorce or legal separation of the Employee and spouse; or
(3) A child ceases to meet the Plan's definition of Dependent.

3. Multiple Qualifying Events: An 18-month period of COBRA continuation coverage may be extended for up to 36 months for your spouse or Dependent child if a second qualifying event occurs (such as if you die, divorce, or your child no longer qualifies for coverage) within the first 18-month period. In no event, however, will such coverage extend beyond 36 months from the date coverage was first lost due to the initial qualifying event.

EXAMPLE: A Participant's Spouse is on COBRA continuation coverage due to the Employee's termination of employment. The Participant passes away

after 12 months of coverage during the 18-month period. His or her death is a second "qualifying event" and entitles the spouse to the remaining balance of 24 months (36-month maximum minus the 12 months that has already been covered).

The period of coverage under this section is reduced by any period in which the Employee or dependent was provided coverage by the Plan at lower cost than coverage under this section pursuant to the subsidized self-pay provisions of the Plan.

C. ELECTION OF COBRA COVERAGE.

Within 60 days after the Plan Office is informed in writing of an event entitling you and/or your Spouse or Dependent child(ren) to COBRA coverage, the Plan Office will provide you with information concerning the coverage available and its cost. You and/or your dependent(s) must elect COBRA coverage within 60 days after your coverage under the Plan ends or the date you receive the election form, whichever is later. Anyone electing COBRA coverage must pay for it retroactive to the date he or she lost coverage under the Plan. Payment for this retroactive coverage is due within 45 days after the date COBRA coverage is first elected. After this first premium, there is a 30-day grace period for making future COBRA payments. No benefit claim will be honored unless the required payment has been received for the period in which the claim was incurred.

If you elect COBRA, you will be entitled to the same health coverage that is provided to active employees or family members in the Plan. Therefore, if there are any changes to the Plan for active employees, your benefits will also change.

You have the option of electing one of the following COBRA Plans and paying the designated premiums:

1. CORE COVERAGE- Provides coverage for medical and prescription drugs only.
2. CORE AND NON-CORE COVERAGE – Provides coverage for medical, prescription drugs, dental, orthodontia, vision and hearing aid.

The premium for COBRA will increase each year. You have the option of changing Medical Plans at the time you elect COBRA subject to residing in the HMO's service area. COBRA premiums are based on your Plan election.

NOTE: FAILURE TO ELECT COBRA WILL RESULT IN YOUR LOSS OF COVERAGE UNDER THE PLAN.

If you and/or any of Your Covered Dependents do not choose COBRA coverage within 60 days after receiving notice, You and/or they will have no group health coverage from this Plan after the date coverage ends.

D. YOUR OBLIGATION TO NOTIFY THE TRUST FUND OFFICE

You are required to notify the Trust Fund Office if you become divorced or legally separated or if there are any other changes in life circumstances that may affect your eligibility for benefits or those of a Dependent.

Plan Participants are also required to immediately notify the Trust Fund Office if your spouse or other enrolled Dependent no longer resides with you. Once a Dependent (including a spouse) no longer resides in your home, that Dependent would no longer meet the definition of an eligible dependent. Consequently, that Dependent would not qualify for coverage under the Plan. A spouse who does not reside with you is no longer entitled to coverage under the Plan. **Please be aware that a spouse no longer residing in the Participant's home, without a legal separation or divorce, is <u>not</u> a qualifying event under COBRA**. However, provided the Trust Fund Office is notified within 30 days of the date of a separation (legal or by joint decision) or a spouse who no longer resides in your home will be allowed the opportunity to purchase coverage at an unsubsidized rate, determined by the Board of Trustees, for up to six months after the date of separation. If within the 6-month period you are able to obtain a legal separation or a final divorce decree, coverage may be extended for a total period not to exceed 36 months (including the first six months of purchased coverage).

E. ADDITION OF NEWLY ACQUIRED DEPENDENTS

If, while You (the Employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with You for adoption, you may enroll that Spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if You do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount You must pay for COBRA Continuation Coverage. Contact the Administrative Office to add a dependent

F. LOSS OF OTHER GROUP HEALTH PLAN COVERAGE

If, while You (the Employee) are enrolled for COBRA Continuation Coverage Your Spouse or Dependent loses coverage under another group health plan, you may enroll the Spouse or Dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or Dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA plan and declined, the Spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or Dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent Child may cause an increase in the amount You must pay for COBRA Continuation Coverage

G. TERMINATION OF COBRA

COBRA continuation coverage will end before the 18-, 29- or 36-month continuation coverage period expires if:

1. **Failure to Timely Pay Premium**: You and/or your Dependent(s) fail to pay the required contribution on time;

2. **Coverage Under Other Plan**: You or your dependent(s) become covered by another group health plan after your COBRA election (except a plan that excludes or limits benefits for a pre-existing condition affecting you or your Dependent and such exclusion or limitation is enforceable under the Health Insurance Portability and Accountability act (HIPAA);

3. **Medicare Entitlement**: You and/or your Dependent(s) become entitled to Medicare after having elected COBRA;

4. **No Longer Disabled**: You or your Dependent(s) qualified for 29-month maximum continuation period based on disability, but are no longer disabled;

5. **Employer No Longer Contributes**: Your Employer who contributed on your behalf ceases to be contributing employer; or

6. **No Active Plan**: The Plan and your employer cease to maintain any health plan for active employees or retirees.

H. CALIFORNIA CONTINUATION BENEFITS REPLACEMENT ACT (Cal-COBRA).

Under the California Continuation Benefits Replacement Act ("Cal-COBRA"), Small Employers with 2 to 19 employees are required to offer terminated Employees and their Dependents the opportunity to continue health insurance coverage. Cal-COBRA is the California program that is similar to Federal COBRA. If applicable, once you have exhausted Federal COBRA Continuation Coverage which generally lasts for up to 18 months, Cal-COBRA may extend continuation coverage for an additional 18 months, up to a combined total of 36 months. However, Employers with over 20 or more employees are subject to Federal COBRA. **Please contact Kaiser for Cal-COBRA eligibility questions.**

V. RETIREE ELIGIBILITY

A. Early Retiree

If you are a retiree, between the ages of 55 and 64 you may want to continue to participate in the Plan's benefits as an early retiree by making self-payments pursuant to a written agreement

provided by the Trust which you will have to sign. To be eligible for the Early Retiree Hospital-Medical Coverage, you must:

- be between the ages of 55 and 64;
- have had medical coverage under this Fund for the last twelve months immediately prior to the last month on which a contribution was made on your behalf by a participating employer.

Any dependents that were listed with the Administration Office at the time of your retirement may also be continued on your coverage. Eligible dependents who survive you may continue to self-pay for the same coverage, if they remain dependents.

B. Normal Retiree

If you are a retiree over the age of 65 and are receiving Medicare Parts A and B coverage you may be eligible for one of the Medicare Supplement or Medicare Risk programs offered by the Plan by making self-payments pursuant to a written agreement provided by the Plan which you will have to sign. To be eligible for the Normal Retiree Medicare Supplement or Medicare Risk programs, you must:

- be age 65 or older;
- have had medical coverage under this Plan for the last twelve months immediately prior to the last month on which a contribution was made on your behalf by a participating employer.

For an additional premium, dependents that were listed with the Administration office at the time of your retirement may be continued on your coverage.

Continuous Plan Coverage is required for eligibility and failure to make timely premium payments will result in loss of coverage. Except as provided below under special enrollment periods, payment for your Retiree coverage must begin the month following your termination from the active employee program so that your coverage is continuous. If you selected "COBRA Continuation Coverage", your retiree coverage must begin at whatever time your Continuation Coverage is terminated. Failure to make the required payments within 15 days of the due date will permanently terminate your coverage.

A retiree who is eligible but not enrolled under the Retiree medical plan will have a special enrollment period if each of the following conditions is met:

1. The retiree was covered under a group health plan or had health insurance coverage at the time coverage was previously offered.

2. The retiree stated in writing that the reason for originally declining enrollment was that he had coverage under another group benefit plan or health insurance coverage.

3. The retiree's coverage described in paragraph 1 either was under COBRA which was exhausted, or the coverage was not under COBRA and terminated as a result of loss of eligibility, or employer contributions toward such coverage were terminated.

4. The retiree requests enrollment under this Plan not later than 30 days after the exhaustion of COBRA coverage or other termination of coverage described in paragraph 3.

A person who becomes a dependent of a retiree through marriage, birth or adoption, shall be entitled to be enrolled in the Plan within 30 days after such marriage, birth or adoption.

More information is available at *www.coveredca.net* or *www.dhcs.ca.gov/services/medi-cal*.

C. MEDICARE COORDINATION--YOU ARE REQUIRED TO ENROLL.

1. Summary of Medicare. Medicare is our country's federal health insurance program for people who worked at least 10 years in Medicare Covered employment who are age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income (SSDI) benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin. If you are not a citizen or permanent U.S. resident, you may not qualify for Medicare. **If you or your Spouse becomes eligible for Medicare, you should carefully read this section. It will tell you what your obligations are concerning enrolling in Medicare Part A and B, how the Plan pays when you are eligible for Medicare, and other important information you need to know.**

Medicare has four parts:

- **Medicare Part Hospital Insurance**. Part A covers inpatient care and certain skilled nursing facilities. Generally, there is no monthly premium, but there are annual deductibles and co-insurance/co-payments after certain lengths of stay.
- **Medicare Part B – Medical Insurance**. Part B covers medical and doctor services, outpatient hospital care and other services. Part B requires payment of a monthly premium, as well as deductibles and co-insurance/co-payments. The member pays an annual deductible and 20% coinsurance. Members continue to pay the Part B premium monthly out of their Social Security check.
  You should enroll in Part B when first eligible to avoid a financial penalty and a potential delay in your enrollment.
- **Medicare Part C – Medicare Advantage Plans**. Health plan options approved by Medicare and administered by private companies.
- **Medicare Part D – Prescription Drug Coverage**. Provided through plans run by insurance companies or other private companies approved by Medicare. There are monthly premiums, deductibles and co-insurance/co-payments.

If a person declines Part B when first eligible, the cost of enrolling in Part B later may be increased by 10% for each full 12-month period that they should have had Part B. The Part B penalty can be waived if a person is still actively employed or their spouse is actively employed and the person has health insurance coverage under an employer/union group health care plan (the employer must have more than 20 employees)

Medicare Part A is financed by payroll taxes, and, if you are eligible to receive it based on your own or your spouse's employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage. Most people are entitled to Part A when they turn age 65 and pay no premium because they or a spouse paid Medicare taxes while working.

The Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) such as hospital inpatient care and skilled nursing facilities (but not custodial or long-term care) and Part B (medical benefits such as medical and doctor services, outpatient hospital care and other services). This means you must enroll in **both Medicare Part A and Part B**, as soon as you are eligible for Medicare. If you do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid and you will be required to pay an additional Retiree Health and Welfare Premium.

IMPORTANT NOTICE: ENROLL IN MEDICARE

To be eligible for Retiree Health and Welfare benefits under this Plan you and/or your eligible Dependent(s) are required to enroll in both Medicare Parts A and B and pay the required premium (for part B) as soon as you and/or your eligible Dependent(s) are entitled to coverage. ***Note: Because Medicare benefits are assigned to your medical plan, you and/or your eligible Dependents can only enroll in one HMO Medicare Plan.***

It is important that you enroll in Medicare Part B when you first become eligible. If you do not, Medicare generally imposes penalties which will significantly increase your Part B premium once you do enroll. The cost of Medicare Part B premium will go up 10% for each full 12-month period an individual was eligible for Medicare Part B during the initial enrollment period but did not enroll. If you did not enroll when first eligible, and later choose to enroll, you must wait until the next Medicare Part B open enrollment period, which is January 1 through March 31 of each year. Your Medicare Part B will be effective on July 1 of the year you enroll. **For enrollment and eligibility information, you should call Social Security at (800) 772-1213. You can also find Medicare information on the Internet at www.medicare.gov.**

To avoid loss of protection, you (or your Dependents) must enroll for Parts A and B of the Federal program during the **three months** before the month in which you (or your Dependents) will become eligible for Medicare. Social Security will automatically enroll you in Medicare Parts A and B. If you have not received your Medicare Card within 2 months of your Medicare eligibility, you should contact the Social Security Administration. Please remember that if you and/or your Dependent are under age 65 but eligible for Medicare, you and/or your Dependent must also enroll for Parts A and B.

EXAMPLE: Below is an example of why it is important for Medicare-eligible individuals to enroll in Medicare Part B coverage.

Assume Bob, a Medicare-eligible Retiree, requires a medical service and most physicians charge $150.00 for it. Assume that Medicare's allowed amount for the services is $100.00, that Medicare would pay 80% of the allowed amount and that the Plan would pay the 20% co-insurance. If Bob is enrolled in Medicare Part B, and has satisfied the Part B deductible, the Plan would pay $20.00 because Medicare would have paid $80.00, and the claim would be considered paid in full. However, if Bob is eligible for but not enrolled in Medicare Part B, then the Plan will still pay $20.00 and Medicare will pay nothing. Consequently, Bob is responsible for $130.00 ($150.00 minus $20.00 paid by the Plan).

To avoid loss of protection, you (or your Dependents) must enroll for Parts A and B of the Federal program during the **three months** before the month in which you (or your Dependents) will become eligible for Medicare. If you have not received your Medicare Card within 2 months of your Medicare eligibility, you should contact the Social Security Administration. **Please remember that if you and/or your Dependent are under age 65 but eligible for Medicare, you and/or your Dependent must also enroll for Parts A and B**.

Effective January 1, 2006, Medicare eligible individuals were given the option of enrolling in the Medicare Part D prescription drug program. Prescription drug coverage in the Plan is not affected by the Medicare Part D prescription drug program and **it is not necessary for you to enroll in Medicare Part D**. The prescription drug benefits you currently receive under this Plan provide better coverage, at less cost to you, than the new drug program under Medicare Part D. As long as you are eligible for a prescription drug plan that has coverage that is equal to or better than what is offered under Medicare Part D, you are considered to have "Creditable Coverage"; therefore, if at some later date you choose to enroll in Medicare Part D, you will not be charged a late penalty for delayed enrollment.

2. Kaiser Permanente Senior Advantage and Blue Shield Medicare Options. The Kaiser Permanente Senior Advantage (KPSA) and Blue Shield plans are available to retired Participants and their eligible Dependents who are enrolled in Medicare Part A and Part B and who reside in a Northern California Kaiser or Blue Shield service area. Retirees with Medicare who enroll in Kaiser or the Blue Shield HMO plans MUST assign their Medicare benefits to Kaiser or Blue Shield (whichever is applicable). The Plan Office will send you a Medicare authorization form when you become eligible for Medicare. Please be aware that the Participant and all eligible Dependents can only be enrolled in one Health Plan option; therefore, a Dependent's eligibility to enroll in these Plans would depend on the Health Plan option selected by the Participant.

If you have any questions regarding the Kaiser Permanente Senior Advantage Program, or require additional information, please call a Kaiser Customer Services Representative at (800) 464-4000. If you have any questions regarding the Blue Shield Plan or require any additional information, please call Blue Cross at 855-256-9404. Or go to: www.blueshieldca.com/policies.

D. Methods of Payment for Retiree Coverage

You must review your agreement to determine how payments will be made for your retiree coverage. If you do not have a copy of your agreement, contact the Administration Office.

E. Retiree Health and Welfare Options

If you qualify for coverage as a normal retiree, you may select from the Medicare Medical Plan offered by this Plan, (any dependents you cover must have the same coverage as you).

If when you retire you are not eligible for Medicare, (are an early retiree, under 65) you may continue in a self-pay basis with one of the Health Plans available through the Fund. You must already be enrolled with the carrier as an active participant to continue as an early retiree paying the designated retiree premium

A RETIREE WHO LOSES ELIGIBILITY WILL NOT BE ABLE TO RE-ESTABLISH ELIGIBILITY

VI. TERMINATION OF COVERAGE

Except as provided under the Self Payments provision, an employee and his/her dependents that has been eligible for the benefits of this Plan shall cease to be eligible for the benefits on the earliest date of:

A. EMPLOYEE.

Employee coverage will terminate on the earlier of:

1. The date the person is no longer eligible because a premium is not timely paid.
2. The date of termination of the Plan or, if any benefit of the Plan is terminated, on the date of termination of such benefit.

B. DEPENDENT.

Your Dependent coverage will terminate on the earlier of:

1. The date the person ceases to be a dependent as defined in the Plan.
2. The date that the Participant who has Covered Dependents ceases to be eligible under the Plan.
3. The date of termination of the Plan, or if any dependent's benefit of the Plan is terminated, the date of termination of such dependent's benefits.

Under certain conditions, your Dependent's Medical expense coverage may be continued after the date it would terminate. See the Continuation of Coverage provisions described on page 31 under COBRA provisions.

NOTE: When both Federally and State-required continuation is available to you and/or your Dependents, a choice must be made. Thus, the advantages and disadvantages of Federal vs. State continuation should be carefully weighed before either is chosen.

VII. MEDICAL BENEFITS

The Plan provides two medical care options. The first is Blue Shield Medical Plan. A separate booklet is available at the Administration Office which describes this coverage. A current Summary of Benefits Coverage for the Blue Shield options are on the Plan's website at www.CALNECA.com. For specific questions about the available Blue Shield benefits, you may go to www.blueshieldca.com/policies or phone 1-855-256-9404.

A. BLUE SHIELD

1. How to receive care

Whenever possible, choose a physician or hospital from the Blue Shield Preferred Provider Network. That way, you'll be sure to receive the highest level of coverage and keep you costs to a minimum. Remember, it is to your advantage to use the Blue Shield of California Preferred Providers for services covered by your plan. When you use a non-Preferred Provider, the Blue Shield of California payment may be substantially less than the Billed Charge. The exception to this is the use of non-Preferred Hospitals for Emergency Services. Further details are contained in the Evidence of Coverage booklet. You will be responsible for that portion of the non-Preferred Provider's bill over and above the amount Blue Shield of California pays. Directories of the Preferred Providers in your immediate area should have been provided to you.

2. About your Blue Shield ID card

You should carry your Blue Shield member identification (ID) card with you at all times and show it to your physician or other health care provider at the time of your visit. You should verify that the provider is a Preferred Provider, in case there have been any changes since your Preferred Provider directory was published. Your ID card lists the following information: Your name (or the name of the principal subscriber if different from you)
Your employer group number

- Your effective date of coverage

If you lose your ID card or need additional copies for other covered family members, please call Blue Shield Customer Service.

For details on your benefit coverage, please refer to Blue Shield's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Self-Funded Medical Plan and its participants.

B. KAISER

1. How to receive care

The Kaiser Permanente facility closest to your home or work is where you will receive most of your care. That's the best way for you to develop a long-term relationship with your physician or other health care professional – and get the best care from Kaiser Permanente.

2. About your Kaiser ID card

Each Kaiser Permanente Health Plan member is assigned a unique Medical Record Number. Each member receives an ID card that indicates this unique number. This number is used to locate your membership and medical information. You should bring your Kaiser Permanente ID card when you seek medical care. The card is for identification only and does not give you rights to services or other benefits unless you are an eligible member of our Health Plan. Whenever you receive a new ID card, be sure to destroy all old cards and begin using the new card.

For details on your benefit coverage, please refer to Kaiser Permanente's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Kaiser Plan and its participants.

Here is a Blue Shield Comparison (Subject to Change at Any Time):

	Blue Shield PPO		Blue Shield HMO	Blue Shield PPO/HRA	
Life and AD&D Insurance	$10,000 for all Active Employees				
Medical Lifetime Benefit Maximum	None		None	None	
	Blue Shield PPO 90/70		Blue Shield HMO	Blue Shield PPO/HRA	
Calendar Year Deductible	Network	Outside	Network Only	Network	Outside
	$100/Person $200/Family	$250/Person $500/Family	None	$1,500/Person $3,000/Family	
Calendar Year Copayment Maximum	$1,000/Person $2,000/Family	$3,000/Person $6,000/Family	$1,000/Person $2,000/Family	$3,000/Person $6,000/Family	$6,000/Person $12,000/Family
	Blue Shield PPO 90/70		Blue Shield HMO	Blue Shield PPO/HRA	
	Network	Outside	Network Only	Network	Outside
Physician Services	10%	30%	$15 per visit	10%	40%
Lab, X-rays, diagnostics	10%	30%	no charge	10%	40%
Hospitalization Services	10%	30%	no charge	$100 + 10%	40%
Emergency Health Coverage (Copay is waived if admitted to	10%	10%	50%	$100 + 10%	$100 + 10%

Hospital)					
Durable Medical Equipment	10%	30%	20% of Allowed Charges	10%	40%
MENTAL HEALTH SERVICES (PSYCHIATRY)					
	Blue Shield PPO 90/70		Blue Shield HMO	Blue Shield PPO/HRA	
	Network	Outside	Network Only	Network	Outside
Inpatient	10%	30%	no charge	$100 + 10%	40%
Outpatient	10%	30%	$15 per visit	10%	40%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE) 40%					
	Blue Shield PPO 90/70		Blue Shield HMO	Blue Shield PPO/HRA	
	Network	Outside	Network Only	Network	Outside
Inpatient (up to 30 days per Calendar Year)	10%	30%	no charge	$100 + 10%	40%
Outpatient (up to 20 visits per Calendar Year)	10%	30%	$15 per visit	10%	40%
PRESCRIPTION DRUG COVERAGE – Prescriptions filled at the pharmacy are for 30-day supply, mail service is for 90-day supply					
	Blue Shield PPO 90/70		Blue Shield HMO	Blue Shield PPO/HRA	
	Network	Outside	Network Only	Network	Outside
Generic	$5 network $10 mail service	25% of billed + $5 co-pay not covered	$10 network $20 mail service	$10 network $20 mail service	25% of allowable amount +$10 co-pay
Brand Name	$10 network $20 mail service	25% of billed + $10 co-pay not covered	$20 network $40 mail service	$25 network $50 mail service	25% of allowable amount + $25 co-pay
Non-Formulary Brand Name	$25 network $50 mail service	25% of billed + $25 co-pay not covered	$35 network $70 mail service	$40 network $80 mail service	25% of allowable amount + $40 co-pay
Specialty Medications	30% up to $150 co-pay per prescription	not covered	20% up to $100 co-pay per prescription	30% up to $150 co-pay per prescription	

KAISER

	Northern California	Southern California
Life and AD&D	$10,000 for all active employees	
Lifetime Maximum Medical Benefit	unlimited	unlimited
Physician Office Visits	$15 per visit	$10 per visit
Maternity Office Visits	$15 per visit	$10 per visit
Hospital Services	no charge	no charge
Skilled Nursing Facility	100 days at no charge	
Diagnostic Lab & X-ray	no charge	
Mental Health – Outpatient	$15 per visit up to 20 visits per year *AB88 Diagnosis= unlimited visits	$10 per visit up to 20 visits per year *AB88 Diagnosis= unlimited visits

Mental Health – Inpatient	no charge – up to 45 days per year	no charge – up to 30 days per year
Substance Abuse Inpatient/Outpatient	$15 per visit- no charge detox only	$10 per visit- no charge detox only
Emergency Room Services	$50 co-pay per qualified ER visit	$35 co-pay per qualified ER visit
Prescription Drugs	$10 generic $25 name brand for 100-day supply or manufacturers smallest package (whichever is greater)	$10 co=pay for 100-day supply
Durable Medical Equipment	Covered only if prescribed and in accordance with DME formulary	

**********THE BENEFITS ABOVE ARE PROVIDED FOR YOUR INFORMATION; HOWEVER, SUCH BENEFITS ARE SUBJECT TO CHANGE AT ANY TIME.**********

VIII. DENTAL BENEFITS (Delta Dental)

The Plan provides dental care through an insured arrangement with Delta Dental. The Plan's Delta Dental Group Number is 00805. A separate booklet, which has been provided for you, is available at the Plan Office which describes this coverage. The Delta phone number is: 800-765-6003.

A. Principal Benefits and Covered Services

- Deductibles & Benefit Maximum: $50 per person, $150 per family per calendar year. *The maximum benefit paid per calendar year is $2500 per person.*
- Diagnostic and Preventive Benefits: 100% of Delta dentist's fee (no deductible apples for these services).
- Basic Benefits: 80% of Delta dentist's fee.
- Prosthodontic Benefits; 50% of Delta dentist's fee (subject to maximum allowance) (bridges, dentures).
- Orthodontic Benefits: 80% of Delta dentist's fee (subject to a $2500 lifetime maximum per person.

B. How to receive care

Under the Delta Premier USA program, you may visit any licensed dentist of your choice, change dentists at any time, go to a dental specialist of your choice, and receive dental care anywhere in the world. *Following are some of the advantages of choosing a Delta dentist.*

- Claim forms are completed and submitted for you at no charge. Your dentist's fees have been certified by Delta as usual, customary and reasonable – you're responsible only for the patient share.
- You may be charged only your copayment and deductible at the time of treatment, not Delta's portion.

If you choose a non-Delta dentist, you may have to complete and submit your own claim forms or pay a service fee; Delta has not certified the dentist's fees and you are responsible for the difference if your dentist charges more than Delta's preapproved fees; and you may have to pay the entire bill at the time of treatment and wait for reimbursement.
Two ID cards will be issued after you are enrolled in the plan. Your ID card will have your group name and number, your name and your Social Security Number. The card is for information purposes only and Delta dentists do not require you to show an ID card. You can see a Delta dentist before you receive your ID card. Just give your dentist your delta Dental group number (805) and your Social Security Number.

For details on your benefit coverage, please refer to Delta Dental's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Dental Plan and its participants.

IX. VISION CARE BENEFITS

A. VSP

The Plan provides vision care benefits through Vision Service Plan www.vsp.com. The Group Number is 12059939-004. The phone number is 800-877-7195. A separate booklet, which you should have, is, available at the Plan Office with complete benefit coverage, limitations, and exclusions.

Vision Services Plan (VSP)
One Market Plaza, Suite 2625, Steuart Street Tower
San Francisco, CA 94105

Member Services: http://www.vsp.com
(800) 877-7195
(800) 428-4833 (toll-free TTY for the hearing/speech impaired)

The Vision Service Plan (VSP) covers each eligible Participant and Dependent for a regular examination and lenses and frames when necessary for proper visual function or correction.

B. To obtain services: To obtain services of a Panel Doctor, an eligible Participant and/or Dependent is requested to contact a VSP participating doctor to make an appointment. Make sure you identify yourself as a VSP member; give your Social Security Number and the group name. The doctor's office will verify eligibility and benefits. If you need to locate a VSP participating doctor, call VSP at (800) 877-7195, or find one at www.vsp.com.

VSP will pay the doctor directly. Except as otherwise provided in this section, you are responsible only for the applicable co-payment **and any additional costs for items only partially covered or not covered. No co-payment applies for contacts**.

If you use a doctor from the VSP network, this assures direct payment to the doctor and guarantees quality and cost control; however, if you decide to use the services of a doctor who is not a VSP Panel Member, you should pay the doctor his or her fee. You will later be reimbursed in accordance with the VSP reimbursement schedule by VSP.

C. Plan Benefits

The VSP plan provides the following benefits:

- Eye exam covered in full once every 12 months – co-pay is $25.00
- Prescription Glasses: Lenses covered in full every 24 months (single vision, lined bifocal and lined trifocal. Polycarbonate lenses for dependent children). Frame of your choice covered up to $120 every 24 months, plus 20% off any out-of-pocket expense.
- Contacts – every 24months; when you choose contacts instead of glasses, your $120 allowance applies to the cost of your contacts and the fitting and evaluation exam. This exam is in addition to your vision exam to ensure proper fit of contacts.
- Laser vision correction discounts.

D. Signature Plan

- 30% off unlimited additional pairs of prescription glasses when purchased the same day as the member's eye exam from the same VSP doctor who provided the exam.
- 30% off unlimited non-prescription sunglasses when purchased the same day as the member's eyes exam from the same VSP doctor who provided the exam.
- New and current contact lens wearers may be eligible for a covered in full contact lens evaluation and initial supply of approved lenses from your newly expanded materials list.

E. How to receive care

- Find a VSP network doctor at vsp.com or call 800-877-7195.
- Make an appointment and tell the doctor you are a VSP member.
- Your doctor and VSP will handle the rest.

For details on your benefit coverage, please refer to Vision Service Plan's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Vision Plan and its participants.

YOUR COVERAGE FROM A VSP DOCTOR	
Exam covered in full	**Every 12 months**
Prescription Glasses	
Lenses covered in full	**Every 24 months**
Single vision, lined bifocal and lined trifocal lenses, Polycarbonate lenses for dependent children	
Frame	**Every 24 months**
Frame of your choice covered up to $120 Plus 20% off any out-of-pocket costs	
-OR- Every 24 months	

Contact Lens Care	
When you choose contacts instead of glasses, your %120.00 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts. Current soft contact lens wearers may qualify for a special contact lens program that includes a contact lens evaluation and initial supply of replacement lenses. Learn more from your doctor or vsp.com	
EXTRA DISCOUNTS AND SAVINGS	
Laser Vision Correction Discounts	
Prescription Glasses Up to 20% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives and up to 20% off additional prescription glasses and sunglasses **Contacts** 15% off cost of contact lens exam (fitting and evaluation) Available from the same VSP doctor who provided your eye exam within the last 12 months	
YOUR COPAYS	
Exam and Prescription Glasses	**$25.00**
Contacts	**No copay applies**
Dollar for dollar you get the best value from your VSP benefit when you visit a VSP network doctor. If you decide not to see a VSP doctor, copays still apply. You'll also receive a lesser benefit and typically pay more out-of-pocket. You are required to pay the provider in full at the time of your appointment and submit a claim within 6 months to VSP for partial reimbursement. If you decide to see a non-VSP provider, call us first at 800-877-7195.	
Out-of-Network Reimbursement Amounts	
Exam	$45.00
Lenses	$45.00
Single Vision	$65.00
Lined Bifocal	$65.00
Lined Trifocal	$85.00
Frame	$47.00
Contacts	$105.00

VSP guarantees service from VSP network doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

THESE PROVISIONS AND AMOUNTS COULD BE CHANGED IN THE FUTURE.

These amounts may change at any time. Please call VSP for vision care request forms at (800) 877-7195 prior to visiting your provider or at **www.vsp.com**.

7. VSP Grievance Procedures: If a Participant has a complaint/grievance (hereafter 'grievance') regarding VSP service or claim payment, the Participant may communicate the

grievance to VSP by using the form which is available by calling VSP Customer Service Department's toll-free number (800) 877-7195 Monday through Friday 6:00 a.m. to 6:00 p.m. Pacific Standard Time. Grievances may be filed in writing within 180 days with VSP at 3333 Quality Drive, Rancho Cordova, CA 95670.

If you are dissatisfied with the results after exhausting VSP's grievance procedures, you may file a written appeal with the Plan's Board of Trustees, as provided in the Claims and Appeals Procedures described in section B, page 82.

The California Department of Managed Health Care ("Department") is responsible for regulating health care service plans and receiving complaints regarding VSP (and similar programs). If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by VSP, you may call the Department's help center toll-free at 888-466-2219. The hearing and speech impaired may use the California Relay Service's toll-free telephone number 1-877-688-9891 (TDD) to contact the Department.

Plan complaint forms and instructions are available online at the Department's website, http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_complaint.aspx.

NOTE: VSP's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law. ***For details on your benefit coverage, please refer to Vision Service Plan's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Vision Plan and its participants.***

X. GROUP LIFE INSURANCE AND ACCIDENTIAL DEATH AND DISMEMBERMENT BENEFIT

Blue Shield of California Life & Health Insurance Company

THIS IS AN OVERVIEW OF BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INCURANCE COMPANY (BLUE SHIELD LIFE) TERM LIFE AND ACCIDENTALDEATH AND DISMEMBERMENT (AD&D) INSURANCE BENEFIT FOR ELIGIBLE EMPLOYEES. PLEASE REFER TO THE POLICY FOR A COMPLETE DESCRIPTION OF BENEFITS.

A. Basic Life Insurance - $10,000

1. **Your Coverage**. The life insurance benefit is $10,000. The benefit will reduce to 65% of the original amount when you reach age 65, and will further reduce to 50% of the original amount at age 70. Coverage will terminate when you retire.

2. **Waiver of Premium Provision**. If you become totally disabled as defined in the policy prior to age 60, you can continue life insurance coverage without paying premiums. The amount of coverage will be the coverage in affect at the time you become disabled. The waiver is subject to reductions and terminations in the policy.

3. **Accelerated Death Benefit**. If you become terminally ill, you may elect an advanced payment of up to 50% of the death benefit. Contact the Insurance Company to determine what proof is necessary to prove you are terminally ill.

B. Basic Accidental Death and Dismemberment (AD&D) Insurance

If you experience an accidental injury as defined by the policy, and the injury directly causes one of the following losses within 90 days of the injury date, AD&D benefits will be paid according to the following schedule. The total benefit for all losses resulting from the same accident may not exceed the principal sum benefit of $10,000.

Basic AD&D Insurance Benefits

Type of Loss	Portion of Principal Sum
Loss of life	100% of the Principal Sum
Loss of one hand by severance at or above the wrist	50% of the Principal Sum
Loss of one foot by severance at or above the ankle	50% of the Principal Sum
Complete and irrecoverable loss of sight in one eye	50% of the Principal Sum
Complete and irrecoverable loss of sight in both eyes	100% of the Principal Sum
Loss of Hearing in one ear	50% of the Principal Sum
Loss of Hearing in both ears	100% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Any combination of two or more of the losses listed above	100% of the Principal Sum
Loss of a thumb & index finger of one hand by complete severance at or above the metacarpophalangeal joints	25% of the Principal Sum
Loss of all four fingers of one hand by complete severance at or above the metacarpophalangeal joints	25% of the Principal Sum
Loss of all the toes of one foot by complete severance at or above the metacarpophalangeal joints	12.5% of the Principal Sum
For the Total paralysis of:	
Both upper and lower limbs (Quadriplegia)	100% of the Principal Sum
Both lower limbs (Paraplegia)	75% of the Principal Sum
Upper/lower limbs of one side (Hemiplegia)	50% of the Principal Sum

C. The Following are also included with Basic AD&D Insurance:

1. **Seat belt & airbags benefit**. If you die as a result of a covered automobile accident while properly wearing a seat belt and with the presence of an airbag, an additional 10% of the principal sum (or $1,000) will be payable in addition to the principal sum.

2. **Special education benefit**. If you die as a result of a covered accident, and you are survived by a spouse and/or one or more dependent children, a special education benefit will be payable for:

- Each dependent child who enrolls full-time at a school of higher learning before the age of 25 (up to $2,500 per year for four years).
- A one-time benefit of up to $5,000 for a spouse who enrolls at an accredited school within one year of the accident for the purpose of retraining or refreshing skills needed for employment.

3. **Repatriation benefit**. If you die at least 100 miles away from your permanent place of residence, and the event is covered under the AD&D benefit, customary and reasonable expenses incurred for the preparation and transportation of your body will be eligible for partial or full reimbursement up to a maximum of $2,000.

4. **Disappearance benefit – After 365 Days**. If you disappear as a result of an accidental wrecking, sinking or disappearance of a conveyance in which you were riding, and your body is not found within 365 days after the date of your disappearance, the AD&D death benefit will be payable.

5. **Felonious assault benefit while working**. If you incur a loss as a result of a felonious assault, an additional 10% of the principal sum will be payable in addition to the principal sum. The felonious assault must be inflicted by someone other than fellow employees or members of your family or household, and must occur while you are working for or on the employer's premises.

6. **Common carrier benefit**. If you die while traveling as a paying passenger on a bus, airline or any other means by licensed common carrier for the purpose of transporting passengers, an additional benefit equal to 100 – 90% of the principal sum will be payable.

7. **Surgical reattachment benefit**. If you are dismembered and that body part is surgically reattached, 50% of the scheduled AD&D benefit will be payable. The remaining 50% of the amount that would otherwise have been payable will be paid if after 365 days the reattachment has failed to the extent that loss of use then exists.

8. **Exposure benefit**. If you are unavoidably exposed to natural elements due to an accidental bodily injury, and as a result of such exposure you incur an otherwise payable loss within 365 days of the date of injury for which payment would otherwise have been made; such loss will be deemed to be a result of the injury and benefits are payable.

8. **Comatose benefit**. If you become comatose within 365 days after the date of the accident and remain so for 60 days, 50% of the principal sum will be payable.

XI. PRESCRIPTION DRUGS

A. PRESCRIPTION DURGS PROVIDED THROUGH YOUR PLAN OF CHOICE

Your prescription drug coverage is provided through either Blue Shield or Kaiser, depending upon which benefit option you have chosen.

B. NOTICE TO THOSE ELIGIBLE FOR MEDICARE PART D

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 created a new prescription drug benefit referred to as Medicare Part D Prescription Drug Coverage (Medicare Part D coverage or coverage). The coverage is available to all Medicare eligible employees and/or dependents that are age 65 or older or are disabled and are receiving Social Security disability benefits, and those with end stage renal disease. The enrollment period for Medicare Part D is November 15th through December 31st.

A notice containing general information about Medicare Part D coverage and this Plan is required to be provided to you (a Medicare eligible individual) by the Plan prior to each annual Medicare Part D enrollment period beginning November 15, 2005. The notice must also be provided to you prior to your initial enrollment period for Medicare Part D coverage, prior to the effective date of your enrollment in this Plan, whenever the Plan's prescription drug coverage ends or changes so that it is no longer creditable, and upon your request. "Prior to" means within 12 months before the event in question.

The Plan intends to continue to provide a prescription drug benefit that is equivalent on a gross basis to Medicare Part D coverage. Therefore, there is no requirement that you enroll in

XII. FEDERAL NOTICES

A. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996.

Pursuant to the Newborns' and Mothers' Health Protection Act of 1996, insurers and group health plans may not restrict benefits for any hospital length of stay for the mother or newborn child to less than 48 hours following normal delivery or less than 96 hours following a cesarean section delivery.

In accordance with Federal Law, plans and insurers may not require that a provider obtain preauthorization from the plan or insurer for prescribing either of the foregoing lengths of stay. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours or 96 hours as applicable. Also, you may be required to obtain precertification for any

days of confinement that exceeds 48 hours (or 96 hours). Furthermore, plans and insurers may not set levels of benefit or out-of-pocket costs so that any portion of the 48-hour (or 96 hours as applicable) stay is treated in a manner that is less favorable to the mother or newborn than any earlier portion of the stay.

B. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998.

Your Plan covers medical and surgical benefits for mastectomies. This coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All states of reconstruction of the breast on which the mastectomy was performed (including coverage for nipple and areola reconstruction, nipple and areola repigmentation to restore the physical appearance of the breast, as a required stage of reconstruction);

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; or

3. Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

The coverage is subject to the Plan's annual deductibles and coinsurance provisions. For more information please call either Kaiser at 800-464-4000, if you are enrolled under the Kaiser HMO plan) or the Plan Office at 408-288-4400, if you are enrolled under the self-funded PPO plan.

C. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA).

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is a federal law that prevents large group health plans (such as this Plan) and health insurers (such as Kaiser) that provide mental health or substance abuse benefits from imposing less favorable benefit limitations, including financial requirements (e.g., deductibles, copayments, coinsurance and out of pocket limitations) and treatment limitations (e.g., number of visits or days of coverage) on those benefits than on medical and surgical benefits offered. As such, the limitations applicable to mental health or substance abuse benefits can be no more restrictive than the predominant limitations applied to substantially all medical and surgical benefits. Pursuant to the Final MHPAEA rules, the Plan or Health Insurer will provide any current participants or potential participants, or contracting providers, upon request, the criteria for medical necessity determinations with respect to mental health/substance abuse benefits and the reason for any denial of reimbursement or payment for services with respect to mental health/substance abuse benefits will also be provided upon request.

It is the intention of the Board of Trustees and the contracted insurers (Kaiser Permanente) that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more information on MHPAEA, please visit the Department of Labor website at *www.dol.gov/ebsa/mentalhealthparity/*.

D. PRIVACY OF PROTECTED HEALTH INFORMATION UNDER HIPAA.

This Plan will use and disclose protected health information ("PHI") in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

PHI is defined as individually identifiable health information that is maintained or transmitted by this Plan in any form or medium (oral, written, or electronic). Individually identifiable health information is health information, including demographic information, that is created or received by a health care provider, employer, health care clearinghouse or this Plan and relates to the past, present or future physical or mental health condition of you and/or your eligible dependents, including payment information for the provision of health care. When held by this Plan, it also means information that either identifies you and/or your eligible dependents directly or indirectly, in that one has a reasonable belief that you or your eligible dependents can be identified using the information. For example, your name, address, birth date, marital status, Social Security Number, and choice of health plan would be considered PHI. Other examples are the amount of contributions paid by your employer for your coverage, or whether you are an active employee, retiree, or Medicare enrollee.

THE FOLLOWING USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) AND CORRESPONDING RIGHTS AND DUTIES APPLY TO YOU AND YOUR ELIGIBLE DEPENDENTS:

1. <u>Permitted Uses and Disclosures of PHI</u>: This Plan and its Business Associates (and subcontractors or agents that perform certain administrative services for the Plan) may use and disclose PHI without your authorization for purposes of treatment, payment and health care operations, but only the minimum amount of PHI necessary to accomplish these activities. Treatment includes but is not limited to the provision, coordination or management of health care among health care providers or the referral of a patient from one health care provider to another. Payment includes but is not limited to actions concerning eligibility, coverage determinations, coordination of benefits, and adjudication of health benefit clams (including appeals), determinations of cost-sharing amounts, utilization reviews, medical necessity reviews, preauthorization reviews, and billing and collection activities. Health care operations include but are not limited to performing quality assessment reviews, implementing disease management programs, reviewing the competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes legal services and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business planning programs, and other related administrative activities.

2. <u>Required Uses and Disclosures of PHI</u>: This Plan must disclose PHI to you upon request to access your own PHI, with limited exceptions, or to request an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of U.S. Department of Health and Human Services ("HHS") and its Office of Civil Rights ("OCR") or other authorized government organizations to investigate or determine this Plan's compliance with the Privacy Rule or when required by a court order. Use and disclosure of PHI may also be required when

the Plan believes in good faith that such disclosure is necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.

3. Agreed to Uses and Disclosures of PHI by You After an Opportunity to Agree or Disagree to the Disclosure: This Plan will disclose PHI to family members, other relatives or close personal friends if the information is directly relevant to the family or friend's involvement with your health care or payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected. However, PHI of persons who are deceased for more than fifty (50) years is not protected under the HIPAA privacy and security rules.

4. Allowed Uses and Disclosures of PHI For Which Authorization or Opportunity to Object is Not Required: This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, worker's compensation programs and correctional facilities.

This Plan may disclose de-identified health information. Health information is considered de-identified if it does not identify you and there is no reasonable basis to believe the information can be used to identify you, such as your name and Social Security Number.

This Plan may disclose summary health information to the Board of Trustees or a Business Associate. Summary health information is PHI, which includes claims history and claims experience, and from which identifying information has been deleted in accordance with the Privacy Rule.
These uses and disclosures are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices For Protected Health Information. Additional copies of these documents may be obtained from the Plan Office.

5. Your Individual Rights: HIPAA and the Privacy Rule afford you the following rights:

- **Right to Request Restrictions.** You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a request. If this Plan agrees, it is bound by the restriction except when otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction. If you wish to make a request for restrictions, please make your request in writing to the Plan's Privacy Officer at the address noted below.

- **Right to Request Confidential Communications.** You (or your personal representative) have the right to request to receive communications of PHI from this Plan either by alternative means or at alternative locations. This Plan may agree to accommodate any such request if it is reasonable. This Plan, however, must

accommodate such a request if you clearly state that the disclosure of all or a part of the PHI could endanger you. You will be required to complete a request form to receive communications of PHI by alternative means or at alternative locations.

- **Right to Inspect and obtain electronic and hard copies of your PHI.** You (or your personal representative) have the right to request access to your PHI contained in a Designated Record Set, for inspection and copying, for as long as this Plan maintains the PHI. A Designated Record Set includes the medical billing records about you maintained by or for a covered health care provider, enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for this Plan or other information used in whole or in part by or for this Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you are not in the Designated Record Set and therefore not subject to access. The right to access does not apply to psychotherapy notes or information compiled in anticipation of litigation. You must complete a request form to access PHI in a Designated Record Set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. This Plan may charge a reasonable fee for the costs of copying. If access to inspect and copy your PHI is denied, a written denial will be provided setting forth the basis for the denial, a description of how you may have the denial reviewed, if applicable, and a description of how you may file a complaint with this Plan or the HHS or its OCR.

- **Right to Amend your PHI.** You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a request form to amend PHI in a Designated Record Set. This Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

- **Right to Accounting of Disclosures.** You (or your personal representative) have the right to request an accounting of disclosures of PHI by this Plan. This Plan will provide such an accounting only for the six-year period preceding the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment or health care operations or made to you about your own PHI. Also, this Plan is not required to provide an accounting of disclosures pursuant to an authorization request or disclosures made prior to the compliance date of the Privacy Rule. You will be required to complete a request form to obtain an accounting of PHI disclosures within 60 days of the request. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the account will be provided. If more than one request for an accounting is made within a 12-month period, this Plan will charge a reasonable, cost-based fee for each subsequent accounting.

- **Right to Notice in Event of Breach.** You have the right to receive and the Plan is required to provide a Notice to you, as soon as reasonably possible, but no later than 60 days after discovery of a breach of your unsecured PHI. There will be a presumption that any unauthorized acquisition, access, use, or disclosure of your PHI, in violation of the Privacy rule is a breach, *unless* the Plan demonstrates that there is a low probability that your PHI has been compromised based on the results of a risk assessment or an exception permitted by the Privacy Rule applies. This Plan has implemented a policy to require the performance of a risk assessment in all cases of impermissible uses or disclosures of PHI to ensure your PHI will not be compromised and intends on complying with any future guidance on risk assessments.

- **Right to Restrict Disclosure of Health Information if Paying Out-of-Pocket.** If you fully paid for services out-of-pocket and you request that the Health Care Provider not disclose your PHI related to those services to the Plan, the Health Care Provider must accommodate your request, except where the Health Care Provider is required by law to make a disclosure.

6. Access by Personal Representatives to PHI: This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal representative with limited health care power of attorney regarding specific treatment, such as use of artificial life support, is your representative only with respect to PHI that relates to decisions concerning this treatment. The personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to take any action.

Proof of such authority may take the form of a notarized power of attorney for health care purposes (general, durable or health care power of attorney), a court order of appointment as your conservator or guardian, an individual who is the parent, guardian or other person acting in loco parentis with legal authority to make health care decisions on behalf of a minor child, or an executor of the estate, next of kin, or other family member on behalf of a decedent.

This Plan retains discretion to deny a personal representative access to PHI if this Plan reasonably believes that you have been or may be subjected to domestic violence, abuse, or neglect by the personal representative or that treating a person as your personal representative could endanger you. This also applies to personal representatives of minors. Also, there are limited circumstances under state and other applicable laws when the parent is not the personal representative with respect to a minor child's health care information.

7. This Plan's Duties: In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The Plan Office has designated this group of employees to include Mail Clerks, Eligibility Certifiers, Supervisors and Managers. The employees described above may only have access to and use and disclose PHI for plan administration functions. A mechanism shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

This Plan and if applicable, the Insurer (ex., Kaiser) is required by law to provide you with its **Notice of Privacy Practices** ("Notice") upon request at any time. The privacy practices for coverage through Kaiser are subject to its own notice. You can view Kaiser's own Notice at www.kaiserpermanente.org. The Notice must be distributed by this Plan to new employees and dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

This Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. This minimum necessary standard, however, will not apply to disclosures to or requests by a health care provider for treatment purposes, disclosures made to you, uses or disclosures pursuant to your authorization, disclosures made to HHS or its OCR for enforcement purposes, uses or disclosures that are required by law, and uses or disclosures that are required for this Plan's compliance with HIPAA's Plan Simplification Rules.

8. Authorization to Use or Disclosure Your PHI: Except as provided for in this section or as permitted by law, the Plan will not release your PHI without your written authorization. Even in situations in which release of PHI may be permitted as described above, the Plan may request your written authorization to release information to the Board of Trustees or others. The Plan Administrator's office has an Authorization Form that you may sign to authorize release of all or part of your PHI. The following uses and disclosures will be made only with your written authorization subject to your right to revoke, amend, or limit your authorization in writing, at any time:

- **Marketing Authorization.** This Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages it use or purchase. (However, this Plan may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided under the plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.)
- **Psychotherapy Notes**. Psychotherapy notes are separately filed notes about your conversations with your mental health professional. Although this Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you.
- **Sale of PHI.** The Plan is prohibited from directly or indirectly receives financial or non-financial remuneration in cash or in kind (including granting license rights) from a third party in exchange for your PHI unless permitted under HIPAA or with your prior written authorization. This Plan does not sell nor does it intend on selling your PHI.
- **Fundraising Purposes.** Except as permitted under HIPAA or with your prior written authorization, the Plan cannot use or disclose your PHI for fundraising purposes. You

have the right to opt out of receiving any fundraising communications whether received in writing or over the phone. This Plan does not use or does it intend to use your PHI for fundraising purposes.

- **Genetic Information.** Your PHI includes genetic information. Although this Plan does not routinely obtain genetic information, regarding underwriting, premium rating, or similar activities, the Plan will not use or disclose genetic information about an individual, as prohibited under the Genetic Information Nondiscrimination Act of 2008.
- **Child Immunization Proof to Schools.** The Plan may disclose proof of immunization of a student to the school prior to admitting the student, where State or other law requires such information, upon obtaining the consent of the parent, guardian or student of consenting age.
- **Other Uses of Health information.** Other uses and disclosures of health information not covered by this Notice or the laws that apply to the Plan will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

9. Duties of the Board of Trustees With Respect to PHI: This Plan will disclose PHI to the Board of Trustees for Plan administration purposes. This may include information pertaining to claims and appeals, including a review of a subrogation claim, or Participant inquiries in limited circumstances, or summary health information so that the Board may solicit premium bids from health insurers or similar entities. The Trustees have amended this Plan's Trust Agreement and signed a certification agreeing not to use or disclose your PHI other than as permitted by the plan documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement, Notice of Privacy Practices for Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Plan Office.

10. Right to File Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Plan Office or with the Secretary of the U.S. Department of Health and Human Services. If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer at:

United Administrative Services
P.O. Box 5057
San Jose, CA 95150-5057
Phone (408) 288-4400

A complaint may also be filed with the U.S. Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. All complaints must be in writing and filed within 180 days of the date you knew or should have known of the violation. This time limit can be waived if good cause is shown. This Plan will not retaliate against you for filing a complaint.

11. <u>Security Standards Under HIPAA</u>: The Board of Trustees will implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of electronic protected health information that the Fund creates, receives, maintains, or transmits on behalf of the Plan pursuant to 45 C.F.R. Section 164.504(f)(1)(ii), enrollment or disenrollment information disclosed pursuant to 45 C.F.R. Section 164.504(f)(1)(iii), or information disclosed pursuant to an authorization under 45 C.F.R. Section 164.508. In implementing such safeguards, the Trustees will:

(1) Ensure that the Adequate Separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;
(2) The Trustees will ensure that any agent, including a sub-contractor, to whom it provides electronic protected health information, agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the information that it creates, receives, maintains or transmits on the Plan's behalf; and
(3) The Trustees will report to the Plan any security incident of which it becomes aware.

XIII. PATIENT PROTECTION AND AFFORDABLE CARE ACT

A. GRANDFATHERED PLAN.

The Board of Trustees believes this Plan is a "Grandfathered health plan" under the federal law known as the Patient Protection and Affordable Care Act of 2010 ("ACA"). As permitted by the ACA, a Grandfathered health plan can preserve certain basic health coverage that was already in effect when the ACA was enacted. Being a Grandfathered health plan means that the Plan is not required to include certain consumer protections of the ACA 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 ACA, 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 Fund Manager. 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. Implementation of the ACA's provisions began with the July 1, 2011, Plan Year.

B. NO PRE-EXISTING CONDITION EXCLUSIONS FOR ANY INDIVIDUAL.

The ACA prohibits insurance plans in the individual and group markets from imposing pre-existing condition exclusions on any individual for Plan Years beginning after January 1, 2014. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to

pay for chemotherapy for an individual with cancer because the individual had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the individual because of the individual's pre-existing medical condition).

C. DEPENDENT CHILD COVERAGE THROUGH AGE 25.

In accordance with the ACA, the Plan will permit a Participant's eligible Child(ren) to be enrolled and maintained as a Dependent through the end of the month in which the Child(ren) attains age 26, regardless of whether the Child(ren) are eligible for coverage through his or her own employer-sponsored group health plan (or his or her Spouse's plan) and regardless of the Child(ren)'s marital status, student status, financial dependency, residency, or employment status.

D. INDIVIDUAL MANDATE & MINIMUM ESSENTIAL COVERAGE.

With certain exceptions, the ACA requires you and your Dependents to have health coverage that qualifies as minimum essential coverage or pay a penalty for noncompliance. Minimum essential coverage includes jointly-sponsored coverage such as this Plan. The ACA also establishes a minimum value standard of benefits for health plans. Minimum value means coverage under a health plan (such as this Plan) meets the minimum value standard if the plan's share of the total allowed costs of benefits provided is 60% or greater. If you are covered under the Plan, you meet the individual mandate. Unless exempt, individuals will have to report their health coverage when filing their income tax returns. The Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.

E. AVAILABILITY OF SUMMARY OF BENEFITS & COVERAGE.

The ACA requires group health plans and health insurers to provide a Summary of Benefits and Coverage, also known as the "SBC", to Participants and their Dependents. The SBC is a standard format, written in easy-to-understand language, summary of what the Plan covers and what it costs. It is intended to help you understand and compare the different benefits and coverage options available to you under the Plan. Under the ACA, you also have a right to request and receive within 7 business days a copy of the Plan's SBC in paper form, at any time and free of charge. The Kaiser and Blue Shield SBC's are on the Plan's website at www.CALNECA.com.

F. ELIMINATION OF LIFETIME & ANNUAL LIMITS ON ESSENTIAL BENEFITS.

The ACA prohibits both grandfathered and non-grandfathered health plans from imposing lifetime and annual dollar limits on Essential Health Benefits. In accordance with the requirements of the ACA, this Plan does not impose any lifetime and annual dollar limits on its Essential Health Benefits. However, the Plan is permitted to impose annual limits on certain non-Essential Health Benefits consistent with the ACA and lawful regulations issued thereunder. Non-Essential Health Benefits means benefits that are not Essential Health Benefits as determined by the Plan and Claims Administrator in its sole discretion. (Please refer to Article J. Section 29 for a definition of Essential Health Benefits.)

G. PROHIBITION ON RESCISSIONS.

Under the ACA, group health plans and insurers must not rescind coverage (meaning cancel or discontinue coverage retroactively) unless a covered individual commits fraud or makes an intentional misrepresentation of material fact. However, a retroactive cancellation or discontinuance of coverage is not a rescission if it: has only prospective effect; is initiated by the covered individual; due to delay in administrative record-keeping; termination of coverage retroactive to the divorce if a plan does not cover former spouses; or attributed to a failure to timely pay required premiums or contributions toward the cost of coverage. In accordance with the ACA, this Plan will not rescind coverage unless permitted by the ACA or you and/or your eligible dependent commits fraud or makes an intentional misrepresentation of material fact.

XIV. THIRD PARTY RECOVERY/SUBROGATIONAND COORDINATION OF BENEFITS

A. ACTS OF THIRD PARTIES/RIGHT OF RECOVERY/SUBROGATION.

If a Covered Person is injured through the act or omission of another party, the following rules apply with respect to payment of benefits from the Plan:

1. The Plan does not cover any illness, injury, disease or other condition for which a third party may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

   You are required to notify the Plan Office if any claims you incur under the Plan are the result of an accident, injury, disease or other condition for which a third party is OR MAY BE liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

   Charges incurred by a Participant or dependent for which a Third Party is responsible are not covered charges under any benefits provided in this Plan; however, payments may be advanced to an otherwise eligible participant or beneficiary, if the conditions of this section are met.

2. The Covered Person agrees to pay to the Plan immediately any proceeds received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorist's coverage or other insurance including the Participant's own or family insurance coverage.) arising out of any claims for damages by the individual or his heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. Any Covered Person who accepts payments from the Plan agrees that by doing so he is making a present assignment of his rights against such third party to the extent of the payments made by the Plan. The Plan may require that any Covered Person execute an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require. Any Covered Person who refuses to execute

an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. Any Covered Person who receives benefits and later fails to reimburse the Plan as set forth above shall be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the Covered Person has failed to reimburse, including reasonable interest on such unpaid funds.

3. The Plan is entitled to a first priority recovery for the full amount of Covered Charges it has paid or may pay for the injury or illness of a Covered Person that are related to the Third-Party Claim. As a condition of receiving benefits under the Plan, the Covered Person grants specific and first rights of subrogation, reimbursement and restitution to the Plan. Such rights shall come first and are not adversely impacted in any way by: (a) the extent to which the Covered Person recovers his/her full damages and/or attorneys' fees; or (b) how such recovery may be itemized, structured, allocated, denominated, or characterized; e.g., without regard to any characterization as a recovery for such matters as lost wages, damages, attorneys' fees, etc. rather than for medical expenses, the type of property or the source of the recovery, including any recovery from the payment or compromise of a claim (including an insurance claim), a judgment or settlement of a lawsuit, resolution through any alternative dispute resolution process (including arbitration), or any insurance (including insurance on the Covered Person, no-fault insurance, or uninsured and/or underinsured motorist coverage).

   Such reimbursement, restitution and subrogation rights shall extend to any property (including money) that is directly or indirectly in any way related to the Plan benefits. Without in any way limiting the preceding, the Covered Person agrees to subrogate the Plan to any and all claims, causes of action, or rights that the Covered Person has or that may arise against any person, corporation, and/or other entity who has or who may have caused, contributed to and/or aggravated the injury or condition for which the Covered Person claims an entitlement to benefits under the Plan, and to any claims, causes of action, or rights the Covered Person may have against any other no-fault coverage, uninsured and/or underinsured motorist coverage, or any other insurance coverage or fund.

4. The Plan's right to subrogation, reimbursement, restitution, to a lien, and as a beneficiary of a constructive trust shall in no way be affected, reduced, compromised, or eliminated by any doctrines limiting its right (equitable or otherwise, whether established at common law or statute) such as the make-whole doctrine, collateral source, contributory or comparative negligence, the common fund doctrine, or any other defense.

5. By accepting payments from the Plan, any Covered Person agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the Covered Person's own carrier for uninsured motorist coverage. A lien shall exist in favor of the Plan upon all sums of money recovered by the Covered Person against the third party. The lien may be filed with the third party, the third party's agents, or the court. The Covered Person shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent. The Plan's claim shall be a lien on said recovery and attach to the recovery or any tangible property that the recovery may be transmuted to. The Covered Person also agrees that until such lien is completely satisfied, the holder of any such property (whether the Covered Person, his/her attorney, an account or trust set up for the Covered Person's benefit, an insurer, or any other holder) shall hold such property

as the Plan's constructive trustee. As such, the constructive trustee agrees to immediately pay over such property to or on behalf of the Plan pursuant to its direction to the extent necessary to satisfy the equitable lien.

6. If the Covered Person settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the Covered Person shall receive no further benefits from the Trust in connection with the medical condition forming the basis of the third party liability claim unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Trust. **The Plan may offset any future claims incurred by the Participant and/or his or her family members against amounts owed to the Plan.**

B. COORDINATION OF BENEFITS WITH OTHER PLANS.

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans are paying for the same claim. To help control costs, this Plan provides a Coordination of Benefits provision. This provision affects all your different benefits under the Plan.

General Coordination of Benefits Rule: If a covered Participant or dependent is entitled to benefits from another plan, the HMOs, insurance companies or other entities likely have rules on which plan is primary or secondary and who pay first. You should consult with these entities to determine the rule. The benefits provided herein shall be paid in accordance with the standardized coordination of benefits provisions of the National Association of Insurance Commissioners.

You may not reject coverage under another Plan, HMO and/or insurance company and/or not enroll in such other Plan, HMO and/or insurance company and then expect this Plan to be primary with respect to payment of your benefits. The other Plan, HMO and/or insurance company would be primary (or you would be responsible for such claims/payments if they refuse such given your failure to enroll or action of un-enrolling).

XV. GENERAL PROVISIONS

A. CONSTRUCTION.

The validity of the Plan or any of its provisions will be determined under and will be construed according to ERISA and other federal law and, to the extent permissible, according to the laws of the State of California. This Plan is intended to be construed, but in the event any provision of this Plan is held illegal or invalid for any reason, such determination will not affect the remaining provisions of this Plan and the Plan will be construed and enforced as if said illegal or invalid provision had never been included.

B. NO VESTED RIGHT.

Nothing in this Plan shall be construed as giving Employees, retired or terminated Employees, Dependents or any other person a vested right to continued coverage under this Plan. The Trustees retain full authority to terminate coverage at any time and/or to increase premiums.

C. AVAILABLE ASSETS FOR BENEFITS.

Benefits provided by this Plan can be paid only to the extent that the Fund has available adequate resources for such payments. No contributing Employer has any liability, directly or indirectly, for such payments. No contributing Employer has any liability, directly or indirectly, for providing the benefits established hereunder beyond the obligation to make contributions and other changes as required in the Collective Bargaining Agreement, if applicable.

In at any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any contributing Employer to make benefit payments or contributions to provide for such benefits. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any contributing Employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

D. INCOMPETENCE OR INCAPACITY.

In the event the Plan determines that the Covered Person is incompetent or incapable of executing a valid document or form and no guardian has been appointed, or in the event the Covered Person has not provided the Plan with an address at which he or she can be located for payment, the Plan may, during the lifetime of the Covered Person, pay any amount otherwise payable to the Covered Person, the Covered Person's spouse, the Covered Person's blood relative, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the event of the death of the Covered Person before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Covered Person: lawful spouse, child or children, mother, father, brothers or sisters, or to the Covered Person's estate, as the Board of Trustees, in its sole discretion, may designate. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

E. GENDER AND NUMBER.

Whenever any words are used in this Plan in the masculine gender, they should be construed as though they were also used in the feminine gender and the singular the plural where they would so apply.

XVI. CLAIMS AND APPEAL PROCEDURES

A. General Rules

The Claims and Appeals procedures set forth below apply only to the Self-funded medical, mental health/substance use disorder, and prescription drug benefits. Claims and appeals for insured benefits are governed by the rules of the specific insurance companies and HMOs. Copies of the applicable claims and appeals procedures for the HMO medical plan, Vision and Dental claims are available from Kaiser, Delta Dental and VSP.

Under the procedures set forth in the Plan and as is required by ERISA, if your claim for a pension benefit is denied in whole or in part, you will receive a written explanation including the specific reasons for the denial. You will be notified in writing of such denial within 90 days after receipt of such application or claim (in most situations, much earlier than 90 days). An extension of time not exceeding 90 days may be required in special circumstances. In many situations, there are delays because of information required by the Plan Office to process an application (such as a birth certificate and/or marriage certificate). You then have the right to have the Board of Trustees review and reconsider your claim. If you have a question regarding the Plan or your benefit, you have the right to submit a letter to the Plan office seeking a response. The Plan will respond within a timely manner (within thirty days).

B. Notice of Adverse Benefit Determination or Denial Notice

It is required that the Plan provide you with specific reasons for denial of benefits and that you be given the opportunity for "full and fair review" of the denial from the provider of service (carrier). Any reference to "you" in includes you and your Authorized representative. An Authorized Representative is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. The Denial Notice will include the following:

a. The specific reason(s) for the denial;
b. The specific reference to pertinent plan provisions (as applicable) on which a denial is based;
c. A description of any additional material or information is necessary to support your claim, and an explanation of why such material or information is necessary;
d. Description on the steps to be taken if you wish to submit your claim for review/appeal and applicable time limits and a statement of your right to sue under ERISA Section 502(a) following your appeal;
e. If an internal rule, guideline or protocol was relied upon in deciding the claim, a statement that a copy is available upon request at no charge;
f. If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge; and

g. For Urgent Claims, a description of the expedited review process (for urgent claims, the notice may be provided orally and followed with written notification).

You have at least 180 days (or longer if your plan agrees) to submit your claim for review.

C. Denial

A decision must be made on your initial request for a plan benefit as follows:

a. Urgent Claims. Claims for urgently needed care must be ruled on "as soon as possible", and in no event more than 72 hours after the claim is filed. The Plan will determine whether a claim is Urgent by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Alternatively, if a physician with knowledge of the patient's medical condition determines that the claim is Urgent, and notifies the Plan of such it will be treated as an Urgent Claim. If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Plan will notify you as soon as possible but not later than 24 hours after receipt of your claim of the specific information needed to complete its review of your claim. You must then provide the specified information within two (2) business days. If the information is not provided within that time, the claim will be denied. During the period in which you are allowed to supply additional information, the normal deadline for making a decision on the urgent claim is suspended from the date of extension notice until the earlier of either two (2) business days or the date you respond to the request. A decision will then be provided by the earlier of no later than 48 hours after receipt of the specified information or the end of the (2) two business day period given;
b. Pre-Service Claims. Claims for pre-approval or pre-authorization benefits must be decided upon within 15 days; and
c. Post-Service Claims. Claims for reimbursement when you have already received care must be ruled on within 30 days. This period may be extended one time for up to 15 days if necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring an extension and the date by which the Plan expects to render a decision.

D. Disability Claims

A Disability Claim must be submitted to the Plan office within 90 days after the date of the onset of the disability. Decisions on disability claims and appeals have different time periods. If the Plan denies your application for disability benefits, the Plan will notify you of the denial within 45 days after the Plan's receipt of your application or claim.

An extension of time no exceeding 30 days may be necessary due to matters beyond the Plan's control. If a decision cannot be rendered due to matters beyond the control of the Plan prior to the expiration of the 30-day extension, the period for making a determination may be extended for up to an additional 30 days, in which event notice will be sent to you prior to the expiration of the first 30-day extension.

The notice of extension will include in addition to the information set forth above, the standards on which entitlement to a benefit is based; the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days to provide the specified information, if any. The deadline for the Board of Trustees to render its decision is tolled from the date on which the notification of the extension is sent to you until the date a response from you is received.

If there is a claim denied related to a disability, the Plan will follow the rules required to be effective as of January 1, 2018.

E. When a Lawsuit May be Started

No Participant, Dependent, Beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein. A Participant may not start a lawsuit to obtain benefits until after either: (1) the Participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since Participant filed a request for review and Participant has not received a final decision or notice that an extension will be necessary to reach a final decision.

No lawsuit may be filed (started) more than one year after services were provided or benefits partially of totally denied or an otherwise adverse determination was made against you or, if the Claim is for short term disability benefits, more than one year after the onset of the disability. The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether the claimant is a "Participant" or "Beneficiary" of the Plan with the meaning of those terms as defined in ERISA. Such claim shall be limited to benefits due to him under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive.

F. Miscellaneous Provisions

Self-funded plan benefits shall be paid only if notice of a claim is made within 90 days from the date on which covered charges were incurred. The claimant must submit properly completed claim forms and itemized statements as authorized by the Board of Trustees. Any exceptions to the submission of the claims later than 90 days are subject to the approval of the Board of Trustees, but in no event may claims be considered for payment later than 15 months from the date on which covered charges were incurred.

In the event the Plan determines that the Covered Person is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Covered Person has not provided the Plan with an address at which they can be located for payment, the Plan may, during the lifetime of the Covered Person pay any amount otherwise payable to the Covered Person, to the spouse, or relative by blood of the Covered Person, or to any other person

or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Covered Person before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Covered Person: Lawful spouse, child or children, mother, father, brothers or sisters, or to the Covered Person's estate, as the Board of Trustees, in its sole discretion, may designate. Any payment in accordance with the provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

No participant, dependent or other beneficiary shall have any right to claim to benefits form the Plan, except as specified. Any dispute as to eligibility, type, amount or duration of the benefits under this Plan or any amendment or modification thereof shall be resolved by the Board of Trustees. The Trustees shall have discretion in any such determination. Participants may seek review of any adverse decision of the Trustees in Federal District Court as prescribed by law.

The benefits provided by the Plan are not in lieu of and do not affect any requirement for covered by Workers' Compensation Insurance laws or similar legislation.

The provisions of the Plan are subject to and controlled by the provisions of the Trust Agreement, if applicable, and in the event of any conflict between the provisions of the Trust Agreement and the provisions of this Plan, the Trust Agreement shall prevail. Certain benefits are self-funded and any references to "insurance" are inapplicable to Self-Funded benefits.

It is recognized that the self-funded benefits provided by the Plan can be paid only to the extent that the Fund has available adequate resources for such payment. No contributing employer, the Local Union nor any individual trustee or the Board of Trustees has any liability, directly or indirectly to provide the self-funded benefits established hereunder beyond the assets available in the Fund and the obligation of contributing employers to make contributions as stipulated in the collective bargaining unit agreements.

WARNING: BENEFITS CAN BE REDUCED OR ELIMINATED

The Board of Trustees reserve the right to reduce or modify any and all benefits of the Plan, in part or in whole, and may change or eliminate any or all insurance carriers, HMOs and any other provider or entity. The Board may also require contributions for any increases to the Plan from time to time from the Participants of the Plan. Any such changes are at the discretion of the Board of Trustees.

XVII. POTENTIAL LOSS/DELAY PAYMENT OF BENEFITS

You and/or your eligible Dependent(s) could lose your benefits and/or have payments delayed in at least the following circumstances:

A. PLAN EXCLUSIONS/CO-PAYMENTS. The Plan and the insurance providers contain exclusions and exceptions for coverage. You should be aware of the Plan's and the insurance provider's limitations, exclusions, co-payments and other facets of the Plan in which you may not receive full payment on a claim or reimbursement or for which there is a co-payment.

B. INELLIGIBLE FOR BENEFITS. The person on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred. For example, if your Employer fails to timely make a premium on your behalf, you lose coverage under the Plan.

C. NOT COVERED/NOT INCURRED. The expenses that were denied are not covered under the Plan or were not actually incurred.

D. FULL BENEFIT PROVIDED. The Person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period.

E. SUBROGATION/THIRD PARTY CLAIMS. The Plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible.

G. COORDINATION OF BENEFITS WITH OTHER PLANS. If Dependents are covered by more than one Plan, this Plan may not be responsible for many claims.

H. WORK RELATED INJURIES. The Plan is not responsible for paying any claims incurred as a result of a work-related injury. This applies even if you have not filed a claim with workers compensation.

I. RIGHT TO RECOVER CLAIMS PAID or Offset of Future Claims/Recover Overpayments. The Plan has the right to recover any amounts improperly paid. The Plan may offset any amounts owed to the Plan against any claims that you and/or a Dependent incur in the future.

J. INADEQUATE OR IMPROPER EVIDENCE. The Plan grants the Board of Trustees the power to deny, suspend or discontinue benefits to a Participant who fails to submit at the request of the Plan Office any information or proof of coverage reasonably required to administer the Plan.

K. FAILURE TO ENROLL IN MEDICARE PARTS A AND B. If you are eligible for and fail to enroll in Medicare parts A and B the Plan will not pay many of your claims. Please refer to page 51, section B for additional information.

L. FAILURE TO COMPLETE APPLICATION. Benefits may not be payable until a completed application and other forms required by the Plan Office are received by the Plan Office.

M. INCOMPLETE INFORMATION/FALSE STATEMENTS. If you fail to provide requested information or give false information to verify disability, age, beneficiary information, marital status or other vital information, coverage under the Plan or benefits provided may be postponed or cancelled. If you make a false statement to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, you will be liable to the Plan for any benefits paid in reliance on such false statements or information. This includes but is not limited to costs incurred by the Plan Office, reasonable attorneys' fees, and interest charges. The Plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

N. PLAN CHANGE. The Trustees amended the Plan's eligibility rules or decreased Plan benefits.

O. FAILURE TO MAKE EMPLOYER CONTRIBUTIONS. If the Contributing Employer did not make contributions on your behalf, you will not be eligible for Retiree Health and Welfare Coverage.

P. PLAN TERMINATION. If the Plan terminates, benefits will no longer be provided.

XIX. AMENDMENT AND TERMINATION OF THE PLAN

A. AMENDMENTS.

The Board of Trustees has the discretion to amend the Plan at any time. Benefit levels and amounts may be changed at any time.

Any amendment may apply to all groups and/or Participants covered by the Plan or only to certain groups of Participants. Retroactive amendments may be made to the extent permissible under ERISA.

B. MANDATORY AMENDMENTS.

Amendments of the Trust or Plan shall be mandatory in the following situations: When necessary to assure compliance with ERISA or other applicable laws; when necessary to assure the tax-deductibility of contributions hereto under federal and state income tax laws; and when necessary to assure that this Trust remains tax exempt.

C. TRANSFER OF ASSETS TO ANOTHER BENEFIT TRUST.

Notwithstanding anything above to the contrary, the Board of Trustees may transfer the Trust assets or any portion thereof to the Trustees of any other trust or trusts which provide similar benefits.

D. TERMINATION.

The Board of Trustees may terminate the Plan at any time subject to the Trust Agreement and applicable Collective Bargaining Agreements.

Upon termination of the Trust, all obligations shall first be satisfied. The Board of Trustees shall thereupon use the remaining Trust assets to provide Plan benefits in such manner as the Plan may provide, or in the absence of a Plan provision, to continue to provide Plan benefits in a manner permitted by ERISA for so long as Trust assets permit.

XXIX. GENERAL INFORMATION

1. Name and Address of the Plan: CAL NECA Health Plan

2. Type of Plan: This is a Health Care Plan, providing the following Health Care Benefits – Hospital, Surgical, Medical, Dental, Vision, Life, and AD&D for active and retiree participants.

3. Type of Administration and Method of Fund Benefits: This Plan is administered by the Board of Trustees. The Plan is funded by employer contributions.

4. Sponsoring Organizations: Participating employers who are members of NECA who contribute to the Plan

5. Contributions: Contributions to the plan are made by eligible employers through subscription agreements and in certain circumstances, self-payment.

6. Fiscal Year: The fiscal year of the Trust is the twelve-month period ending each December 31st, and the Trust's records are maintained on that basis.

7. Employer Identification Number: 23-7120690/ **Plan Number**: 501

8.Contract Administrator:

United Administrative Services
6800 Santa Teresa Boulevard, Suite 100
San Jose, CA 95119
Phone (408) 288-4400

9. Name and Address of Agent for Service of Legal Process:

Dick Grosboll
Neyhart, Anderson, Flynn & Grosboll
Attorneys at Law
369 Pine Street, Suite 800
San Francisco, CA 94104-3323
Telephone: (415) 677-9440

XX. HIPAA—LIST OF HEALTH PROVIDERS

In accordance with the new disclosure requirements of the Health Insurance Portability and Accountability Act, we are informing you of the names and addresses of the Heath Providers for the Trust Fund and their roles (i.e., whether they guarantee the payment of benefits or provide administrative services).

List of Providers

Blue Shield of California
224 Airport Parkway
San Jose, CA 95128
Phone: 1-855-256-9604 www.blueshieldca.com/policies
Provides prepaid life, medical and AD&D benefits with guaranteed payment of these benefits.

Delta Dental
100 First Street
San Francisco, CA 94105
(415) 977-7931
Provides prepaid dental benefits with guaranteed payment of these benefits.

Kaiser Foundation Health Plan
1800 Harrison Street, 13th Floor (North)
Oakland, CA 94120
(510) 625-3102
393 E. Walnut Street, 5th Floor (South)
Pasadena CA 91188
(626) 405-6501 www.kp.com
Provides prepaid medical benefits with guaranteed payment of these benefits.

Vision Service Plan
333 Quality Drive
Rancho Cordova, CA 95670
Phone: 1-800-877-7195
Provides the prepaid vision plan for participants and dependents.

ERISA requires that we inform you of the Department of Labor address in Washington, D.C. If you have any questions about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. Additional information regarding your ERISA rights may be under "Statement of ERISA Rights".

The Plan provides dental care through an insured arrangement with Delta Dental. A separate booklet is available at the Administration Office which describes this coverage.