

Notice of Changes to Summary Plan Description

To: All Plan Participants
From: EISB, Inc.
Date: January 2008

The Board of Trustees of the San Francisco Electrical Workers Health & Welfare Trust (the "Plan") have recently approved several amendments to the Plan effective on January 1, 2008. Those changes are summarized below.

A. Changes in Dependent Enrollment Rules

The amendment simplifies and clarifies the Plan's definition of "Domestic Partner" and how a Domestic Partner is required to verify whether he or she is also a dependent of the Participant for tax purposes. The amendment also gives additional discretion to the Trustees to allow retroactive enrollment in the Indemnity Plan for a Participant's Dependent who is a dependent for tax purposes. The sections of the Summary Plan Description that were changed by this amendment now read as follows:

Section II.C (Dependent Eligibility Rules):

1.(b) **Domestic Partner Defined.** "Domestic Partner" means an individual who is your spousal equivalent as sanctioned by the laws of a state, county, city or other municipality, and for whom an official certification of registration of domestic partnership has been submitted to the Plan Office.

5. **Proof or Certification of Dependent Status.** You may be required by the Plan to prove or certify initial and continuing tax dependent status for any individual you enroll as a Dependent.

6. **Notification of Cessation of Dependent Status.** You must notify the Plan immediately if any individual ceases to be your Dependent or, in the case of a Domestic Partner who was your dependent under the tax rules, ceases to be your dependent under the tax rules.

Section II.D (Plan Selection and Enrollment):

2. **Open Enrollment.** You may change Plan selections during special open enrollment periods which generally occur during the month of July, with changes effective August 1st. The Plan will send open enrollment material with Plan information to you shortly before each open enrollment period. Be sure to enroll your Dependents when you first enroll. Otherwise, subject to Special Enrollment provisions in paragraph 3, below, you may enroll your Dependents only during open enrollment. All of your Dependents are covered in the same option that you choose for yourself, if they are properly enrolled in the Plan. The Board may change or establish other open enrollment periods.

Tax Withholding Rule for Domestic Partner Coverage. If your Domestic Partner is not also your dependent for income tax purposes, the law requires the Plan to report the value of coverage of your Domestic Partner as taxable income, and collect applicable payroll taxes. Your Domestic Partner who is not your tax dependent will not become covered under the Plan until you have deposited with the Plan an amount of money sufficient to cover at least 6 month's of withholding taxes, including the employer's portion of applicable social security taxes. The Plan is not responsible for any taxes, tax-related penalties or interest imposed on you as a result of providing Domestic Partner coverage. The Plan will continue to require advance payment of taxes so long as your Domestic Partner is covered under the Plan and is not your tax dependent.

3. **Special Enrollment.** Because Plan benefits are generally available to you without cost, you will ordinarily want to enroll in the Plan, along with your spouse or Domestic Partner and other Dependents. However, for various reasons you might want to decline enrollment for an otherwise eligible family member (for example, to avoid taxable income for covering a Domestic Partner who is not a dependent under the Internal Revenue Code). If you fail to enroll in the Plan any eligible Dependent who has other health insurance coverage, you may later enroll that Dependent if you request enrollment within 30 days after that other coverage ends. Also, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents if you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, the Plan will generally approve coverage for your unenrolled Dependent back to August 1st of the current Plan Year provided (i) that Dependent is your dependent under the Internal Revenue Code, (ii) you are enrolled in the Indemnity Plan or you are enrolled in one of the Plan's HMOs that will reinstate coverage for that Dependent, and (iii) such coverage is requested in writing to the Plan Office.
5. **Proof or Certification of Dependent Status.** You may be required by the Plan to prove or certify initial and continuing tax dependent status for any individual you enroll as a Dependent.
6. **Notification of Cessation of Dependent Status.** You must notify the Plan immediately if any individual ceases to be your Dependent or, in the case of a Domestic Partner who was your dependent under the tax rules, ceases to be your dependent under the tax rules.

B. New Benefit for Colorectal Cancer Screening

The Indemnity Plan will cover various screening tests to help find colorectal cancer itself or identify and remove precancerous polyps (growths in the colon). The section of the Summary Plan Description that were changed by this amendment now read as follows:

Section V.A.4 (Covered Charges Under the Indemnity Plan)

(mm) **Colorectal Cancer Screening.** The Indemnity Plan will cover colorectal cancer screening, generally applying the same eligibility rules that Medicare applies to Medicare beneficiaries when determining eligibility for colorectal cancer screening. Those rules can be reviewed at www.cms.hhs.gov/colorectalcancerscreening.

C. New Limited Indemnity Plan Benefit for Treatment of Autistic Symptoms

The Indemnity Plan will provide a benefit limited to \$3,000 per year for the treatment of certain symptoms that are suspected of being related to the condition of autism. The section of the Summary Plan Description that were changed by this amendment now read as follows:

Section V.B (Medical Plan Limitations and Exclusions):

3. **Experimental or Not Generally Accepted Treatment.** Subject to the exceptions described below, charges incurred for a treatment that is not generally accepted by the medical profession, or is listed as Experimental, under Investigation, or limited to research by the FDA, the American Medical Association (“AMA”), Diagnostic and Therapeutic Technology Assessment (“DATTA”) or the Office of Medical Application of Research of the National Institute of Health Office of Technology Association (“OMT”). If a treatment has not been addressed by one of the organizations listed in the preceding sentence, the Plan may determine if a treatment is appropriate based on the advice of its medical review department and/or an independent medical reviewer and other medical experts.

Exceptions. Coverage for treatment described in this paragraph will not be denied if either of the following exceptions apply:

(i) *Certain FDA Approved Drugs Prescribed for Unapproved Purposes.* The coverage is for an FDA-approved drug that is used to treat a condition for which the FDA has not approved the drug’s use, but only if the drug is prescribed for the treatment of a life-threatening condition and the drug has been recognized for treatment of that condition by the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information or the United States Pharmacopeia Dispensing Information, Volume I, “Drug Information for the Health Care Professional.” “Life-threatening,” for this purpose, means either (or both) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(ii) *Certain Suspected Physical Causes of Autistic Symptoms.* The coverage is for alternative treatment for a condition suspected of playing a role in the expression of symptoms of autism, including:

- vitamin supplementation therapy;
- oral secretin therapy;
- chelation;
- hyperbaric oxygen therapy;
- cranio-sacral therapy;
- fibroblast growth factor therapy;
- live cell and stem cell therapy;
- anti-fungal therapy;
- antibiotic therapy; and
- naltexone therapy.

Covered charges allowed under this exception (ii) shall not exceed \$3,000 for any Calendar Year.

Any questions concerning the above changes may be directed to the Plan Office at (415) 263-3670.