SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN

SUMMARY PLAN DESCRIPTION
and
PLAN DOCUMENT

Effective as of February 1, 2023

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN
720 Market Street, Suite 700
San Francisco, CA 94102-2509
415-263-3670

February 2023

DEAR PARTICIPANT:

Attached is the restated Plan document and Summary Plan Description ("SPD") for the San Francisco Electrical Workers Health & Welfare Plan ("Plan") which has been established for you under collective bargaining agreements between the International Brotherhood of Electrical Workers Local 6 and the San Francisco Electrical Contractors Association, Inc. It describes your health, group life, disability and other benefits, the requirements for Plan eligibility, claims and appeals procedures, and other important information. Please read this SPD carefully to understand your benefits. It is effective for the Plan year beginning February 1, 2021.

This document is subject to, and does not modify or interpret, the insurance policies and contracts between the Plan and the Plan's insurers and providers of care. Separate booklets describing the benefits under one of the Plan's Health Maintenance Organizations ("HMOs") or other insured benefit are available to you free of charge upon request. The supplemental booklets, which are treated as a part of this Plan, describe benefits, eligibility, claims and review procedures, and other matters.

You must inform the Plan Office of any change in your address, marital or domestic partnership status and the status of any of your Dependents, and provide any requested information pertinent to the administration of the Plan. Failure to do so may result in the loss of benefits or coverage. If you must pay for any of your coverage by making monthly payments, be sure you understand the rules regarding Monthly Coverage Payments. Failure to follow these rules may cause a loss of eligibility.

The Plan is administered subject to the terms of this Plan document and the San Francisco Electrical Workers Health & Welfare Trust, and we, as the Board of Trustees, have the authority and discretion to interpret, construe and apply the Plan's terms, and decide all issues of eligibility and benefits that arise under the Plan.

To assist with day-to-day administration, we have hired the Electrical Industry Service Bureau ("EISB"). EISB may respond informally to your oral questions, though oral responses do not bind us or the Plan and cannot be relied on in any dispute concerning your benefits.

Plan rules and benefits change from time to time. Your Plan benefits are not vested, and may be eliminated or changed by the Board at any time and on very short notice. You may also be required to make new or additional contributions for benefits provided by the Plan. Any wording that may be contrary to Federal law is to be understood to meet the standards of such laws. In addition, any changes in Federal law that may affect the Plan will automatically be incorporated into the Plan, if required.

If you are about to retire, you must apply for Medicare to receive full benefits because enrollment for Medicare benefits is not automatic. Medicare Part A is free of charge and provides hospital benefits; Part B provides supplemental insurance for a monthly premium; and Part C provides HMO benefits as an alternative to Parts A and B. Medicare Part D provides prescription drug benefits, but you should not enroll in Medicare Part D. This Plan coordinates retiree benefits with Medicare and assumes you are covered under Medicare Parts A and B, or Part C if applicable. If you do not enroll in Medicare as soon as you are eligible, the Plan will **not** cover the portion of your expense that Medicare would have paid. So, as soon as soon as you are eligible for Medicare, please enroll and notify the Plan Office immediately.

Sincerely, Board of Trustees

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN

This is the San Francisco Electrical Workers Health & Welfare Plan, as maintained pursuant to a Collective Bargaining Agreement and Declaration of Trust negotiated by the International Brotherhood of Electrical Workers, Local 6 ("Local 6"), and the San Francisco Electrical Contractors Association, Inc. ("SFECA"). This document constitutes both the Plan's plan document and its summary plan description. You should review this document to understand your rights under the Plan.

I. DEFINITIONS

The following terms have the meaning set forth below, unless the defined meaning is plainly inapplicable.

ACA means, collectively, the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152.

Active Coverage means coverage provided to an Active Employee, and any other coverage that is expressly treated as Active Coverage.

Active Employee means an Employee who has satisfied the initial eligibility requirements of Section 3.2 and continues to be eligible under Sections 3.3 or 3.4.

Blue Shield means Blue Shield of California, an independent member of the Blue Shield Association.

Blue Shield HMO means the HMO made available to Participants under Article IX that is maintained by Blue Shield.

Board means the Board of Trustees of the Trust.

Child means the Employee's, the Employee's Spouse's or Domestic Partner's, natural child, stepchild, legally adopted child, foster child, or other child for whom the Employee, Spouse, or Domestic Partner has been appointed legal guardian or is required to provide dependent coverage pursuant to a QMCSO under Section 5.3; provided, however, that any such individual shall be so treated only through the month in which the individual attains age 26.

COBRA Coverage means a Covered Individual's continuation of Plan coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, as generally provided in Article VII.

Collective Bargaining Agreement means any collective bargaining agreement entered into by Local 6 and SFECA that provides for contributions to the Trust, as it may be amended from time to time. (See Appendix A for a list of the Collective Bargaining Agreements in effect as of the Effective Date.)

Contribution Agreement means an Employer's agreement to contribute to the Plan pursuant to a Collective Bargaining Agreement, Subscription Agreement or the Reciprocal Agreement. (See Appendix A for a list of the Contribution Agreements in effect as of the Effective Date.)

Covered Charge means a charge described in Section 8.9.

Covered Employment means, except as expressly provided otherwise, service as an Employee, any Military Service described in Section 6.8, and any Qualified Trustee Service;

provided, however, that any service as a responsible management employee (RME) and responsible management official (RMO) is excluded.

Covered Individual means any Participant or covered Dependent.

Custodial Care means treatment, services or confinement that could be rendered safely and reasonably by a person not medically skilled, and which are designed mainly to help the patient with activities of daily life, including personal care, homemaking services, moving the patient, acting as companion or sitter and supervising medication that can ordinarily be self-administered.

Dependent means an Employee's Spouse, Domestic Partner and any Child.

Domestic Partner means a Participant's spousal equivalent under 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. In order to effectuate enrollment of a Domestic Partner, the Plan Office must receive (i) proof of Domestic Partner status in the form of an official certification of registration of domestic partnership and (ii) either (a) an "affidavit of dependency" for tax purposes or (b) advance remittance of at least six months of taxes that the Plan Office determines are due on any additional imputed federal taxable income to the Participant, including the Employer's portion of such taxes. The Plan shall treat the effective date of a Participant's domestic partnership as if it were the date of marriage. (See, for example, the Special Enrollment provisions of Section 6.4, which also applies to Domestic Partners.) The term "divorce" or "dissolution" in this Plan is deemed to include the legal termination of a domestic partnership.

Effective Date means February 1, 2023.

EISB means the Electrical Industry Service Bureau, Inc., the entity engaged by the Board to serve as the Plan's contract administrator for day-to-day Plan administration.

Employee means an individual performing work requiring contributions to the Plan under a Contribution Agreement.

Employer means an employer that is obligated to contribute to the Plan under a Contribution Agreement.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

ESRD means end-stage renal disease.

Experimental or Not Generally Accepted means, subject to the exceptions described below, and regardless of any claimed therapeutic value, experimental or investigational, limited to research by the FDA, the American Medical Association (Diagnostic and Therapeutic Technology Assessment) or the Office of Medical Application of Research of the National Institute of Health Office of Technology Association, or is not generally accepted by specialists in that particular field of medicine, as determined by the Plan's medical review consultant and/or an independent medical reviewer. 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 Experimental or Not Generally Accepted based on the advice of its medical review department and/or an independent medical reviewer or other medical experts. For this purpose, "Generally Accepted" means treatment or service that (i) has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature, (ii) is in general use in the medical community and (iii) is not under continued scientific testing or research as a therapy for the particular injury or sickness which is the subject of the claim.

Exception 1: Certain FDA Approved Drugs Prescribed for Unapproved Purposes. Coverage is provided for an FDA-approved drug that is used to treat a life threatening condition for which the FDA has not approved the drug's use, if 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.

Exception 2: Certain Suspected Physical Causes of Autistic Symptoms. Coverage is provided for alternative treatment of a condition suspected of playing a role in the expression of symptoms of autism, limited to $3,000 per calendar year. This treatment is considered experimental, and not an essential health benefit within the meaning of the ACA, and therefore can be subject to an annual benefit maximum. The alternative treatments currently include:

(1) vitamin supplementation therapy;

(2) oral secretin therapy;

(3) chelation;

(4) hyperbaric oxygen therapy;

(5) cranio-sacral therapy;

(6) fibroblast growth factor therapy;

(7) live cell and stem cell therapy;

(8) anti-fungal therapy;

(9) antibiotic therapy; and

(10) naltexone therapy.

FDA means the U.S. Food and Drug Administration.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

HMO means, in the general context, a health maintenance organization and, in the specific context, either or both the Blue Shield HMO or the Kaiser HMO.

Hospital means an institution that:

(a) is primarily engaged in providing, by or under the supervision of Physicians, in-patient diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or rehabilitation of injured, disabled or sick persons;

(b) maintains clinical records on all patients;

(c) has bylaws in effect with respect to its staff of Physicians;

(d) has a requirement that every patient be under the care of a Physician;

(e) provides 24-hour nursing service rendered or supervised by a registered professional nurse;

(f) has in effect a hospital utilization review plan;

(g) is licensed pursuant to any state or agency of the state responsible for licensing hospitals; and

(h) has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals. The term does not include an institution, or that part of an institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational services.

Hour Bank means the system of accounting, as described in Section 3.1, for a Participant's monthly hours of Covered Employment and corresponding Employer contributions received for those work hours for purposes of determining eligibility for Plan coverage.

IBEW means the International Brotherhood of Electrical Workers.

Illness means a bodily disorder, infection or disease, including all related symptoms and recurrent conditions resulting from the same causes.

Injury means physical harm sustained to the body as the direct result of an accident, affected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

Kaiser HMO means the HMO made available to Participants under Article IX that is maintained by Kaiser Foundation Health Plan, Inc.

Local 6 means the International Brotherhood of Electrical Workers, Local 6.

Medically Necessary means that the treatment must be, and **Medical Necessity** refers to a treatment that is, ordered by a Physician or Other Accredited Provider to diagnose or treat an Injury or Illness, and be:

(a) generally recognized as effective and essential to the treatment of the Injury or Illness for which it is ordered;

(b) appropriate for the symptoms and consistent with the diagnosis; and

(c) the appropriate level of care, and which (i) is provided in the most appropriate setting, based on the diagnosis and condition, (ii) could not have been omitted without an adverse effect on the Covered Individual's condition or the quality of medical care, (iii) is based on generally recognized and accepted standards of medical practice in the United States, and (iv) is neither:

(1) Experimental or Not Generally Accepted or primarily limited to research in its application to the Injury or Illness;

(2) primarily for scholastic, educational, vocational or developmental training;

(3) primarily for the comfort, convenience or administrative ease of the Covered Individual, Physician or Other Accredited Provider or member of his or her family or caretaker; nor

(4) Custodial Care.

The Plan may rely on its medical review department and/or an independent medical reviewer to determine if treatment is Medically Necessary. The fact that a Physician orders treatment is not, by itself, sufficient to make it Medically Necessary.

Medicare means the benefits provided under Title XVIII of the Social Security Amendments of 1965.

Mental Health Parity and Addiction Equity Act means the federal law (Pub. L. 110-343) that disallows health plans that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical and surgical benefits.

Monthly Coverage Payment means a monthly payment that a Covered Individual must make to the Plan in order to maintain coverage for a month.

NECA means the National Electrical Contractors Association, Incorporated.

No Surprises Act means the law included in the Consolidated Appropriations Act of 2021, Pub. L. No. 116-260, that generally prohibits surprise balance billing by certain out-of-network providers for certain categories of services.

Other Accredited Provider means a Physician's assistant, nurse practitioner, midwife or nurse midwife, who provides medical care within the scope of a license or certificate.

Participant means an Employee or Retiree who is covered under the Plan.

Pension Plan means the Northern California Electrical Workers Pension Plan.

Physician means a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) authorized to perform medical or surgical services within the lawful scope of his or her practice, and any other health care provider having substantially equivalent status under state law. Chiropractor, occupational therapist, speech therapist, and physical therapist are examples of health care providers that do not meet the definition of Physician.

Plan means this San Francisco Electrical Workers Health & Welfare Plan.

Plan Office means the administrative office of the Plan, which is currently managed by EISB.

Preventive Care means items or services required to be covered without cost-sharing (copayment or coinsurance charges) when delivered by an in-network provider. (See Section 8.9 for examples.) A comprehensive list can be found at: www.HealthCare.gov/center/regulations/prevention.html and additional information regarding the U.S. Preventive Services Task Force recommended services receiving grades A or B is located at www.uspreventiveservicestaskforce.org.

Qualified Trustee Service means those hours of service by an Employee (not to exceed seven per day) that would have constituted covered employment under a Collective Bargaining Agreement but for the Employee's service as a trustee of the Trust or the Northern California Electrical Workers Pension Trust. Such hours shall be treated under this definition as if they were performed.

Reasonable and Customary means falling within the common range of fees billed by a majority of health care providers for a covered procedure in a given geographic region, or which is justified based on the complexity or the severity of treatment for a specific case, as determined from time to time by the Board. For this purpose, "region" means a county or greater area that is

necessary to obtain a representative cross-section of the usual charges made. The Plan applies a widely-used claims data base at the 90th percentile to determine Reasonable and Customary (that is, the charge may not exceed the amounts normally charged by 90% of the Physicians in the data base in a particular geographical area).

Reciprocal Agreement means the Electrical Industry Health and Welfare Reciprocal Agreement, effective with respect to the Plan as of 1996, as it may be amended from time to time. (Check with the Plan Office for any recent changes to the Reciprocal Agreement.)

Regular Retiree means a Retiree who has met the requirements of Section 4.1(a).

Retiree means a IBEW member in good standing who formerly, but no longer, performs services in the electrical industry.

Self-Funded PPO means the coverage option describing benefits paid directly by the Plan, as set forth in Article VIII.

SFECA means the San Francisco Electrical Contractors Association, Inc.

Spouse means an Employee's legal spouse under State law (if recognized by federal law).

Subscription Agreement means a written agreement, other than a collective bargaining agreement, between the Board and an employer to provide Plan coverage for the employer's employees, and which shall set forth the terms and conditions for participation in the Plan.

Trust means the San Francisco Electrical Workers Health & Welfare Trust, as established under the Trust Agreement.

Trust Agreement means the trust agreement establishing the Trust, as it may be amended from time to time.

Trustee means any member of the Board.

II. OVERVIEW AND ADMINISTRATION

2.1 Establishment and Continuation. The Plan was originally effective as of June 1, 1953, has been amended frequently, and continues under this amended restatement effective as of the Effective Date. The Plan is maintained for the exclusive benefit of Participants, their Dependents and beneficiaries, and shall conform to the requirements of ERISA.

2.2 Board Composition. The Plan is administered by a board of six trustees and up to two alternate trustees. An even number of Trustees is selected each by SFECA and by Local 6. The current Trustees are listed in Appendix E. The Trust Agreement permits alternate Trustees to attend all meetings and take action when a regular Trustee is not available.

2.3 Board Responsibilities. The Board has many powers and functions, including investing the Plan's assets, interpreting Plan provisions, amending the Plan, deciding policy questions, determining benefit program options (*e.g.*, insured or self-funded, HMO or PPO) and contracting with service providers such as consultants, auditors, attorneys, and investment managers. The Board is the named fiduciary of the Plan with the sole authority to control and manage the Plan's administration. The Board is authorized to interpret the Plan, and only its authorized agents (such as EISB) may otherwise act on its behalf. The Board has the sole ultimate discretionary authority to determine eligibility for benefits, adopt and apply such rules of administration as it deems appropriate, and construe the terms of the Plan and other related documents. Neither an individual Trustee, Local 6, a Local 6 representative, SFECA, an Employer,

nor any Employer representative, is authorized to interpret the Plan or act on behalf of the Board. The rules, interpretations, computations and actions of the Board shall be binding and conclusive on all persons.

2.4 Plan Office Responsibilities. The Board has hired EISB to carry out the day-to-day tasks of administering the Plan. EISB may be contacted at:

EISB
720 Market Street, Suite 700
San Francisco, California 94102-2509

Tel: (415) 263-3670

The Board has granted EISB and Blue Shield limited discretionary authority to decide your initial claim for benefits (but not any subsequent appeal) with respect to eligibility and PPO claims under the claim and appeal procedures of Appendix C. In all other cases, EISB applies the plain terms of the document and does not exercise discretion.

2.5 Employer Contributions. Monthly Employer contributions are made to the Plan for the hours you work in Covered Employment at rates that are set in your Employer's Contribution Agreement. For example, the hours you work in January generate contributions from your Employer that are received (if timely paid) in February, and which are then credited to your Hour Bank effective March 1. Each monthly contribution made by your Employer is accompanied by a transmittal report containing information (names, SSNs, hours worked, *etc.*) that supports the amount of the contribution. The Plan Office checks the Employer's transmittal report for mathematical accuracy and notifies the Employer if there is any error in the Employer's computations requiring correction. Separate from Employer contributions, contributions may also paid into the Plan pursuant to the reciprocity rules described in Section 3.5.

IF YOU BELIEVE YOUR EMPLOYER IS NOT CONTRIBUTING THE FULL AMOUNT IT OWES . . .

PLEASE NOTIFY THE LOCAL 6 OFFICE AND PLAN OFFICE IMMEDIATELY.

2.6 Plan Amendment and Termination. The Board expressly reserves the right to amend or terminate the Plan, in whole or in part, at any time. For example, the Board may:

(1) terminate or amend either the amount or condition of any benefit even though such termination or amendment might affect claims that have already accrued;

(2) change the minimum number of hours required in your Hour Bank to provide coverage for a calendar month;

(3) alter or postpone the method of payment of any benefit;

(4) merge the Plan with other plans, including the transfer of assets; or

(5) terminate any vendor contract, including an HMO or insurance company.

The authority to make any such changes to the Plan rests solely with the Board. Any such amendment or termination of the Plan shall be made by a resolution adopted by the Board and be consistent with the terms of the Trust Agreement. You will be notified if there are important amendments to the Plan. 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 plans.

2.7 Benefits Conditioned on Availability of Funds. Plan Benefits can be paid only to the extent that the Plan has adequate funds to pay for the benefits. No Employer has any liability, directly or indirectly, to provide Plan benefits beyond the obligation to make contributions under its Contribution Agreement. Similarly, neither the Board nor any individual Trustee, nor Local 6, nor any other person, has any liability to pay Plan benefits should the Plan become depleted of funds.

2.8 Special Exclusion for Fraud. No payments will be made by the Plan for benefits obtained through fraud, including, but not limited to, the coverage of any individual who was fraudulently represented to the Plan to be the Participant's Dependent. Any Covered Individual, or any other person, who assisted with, or benefited from, the fraudulent conduct is liable to the Plan for repayment of any benefits improperly paid as a result of the fraud. If the Covered Individual has any outstanding liability for fraudulently paid benefits, no assignment may be made of any rights to benefits to a service provider or other person until all fraudulently paid benefits have been repaid in full. If fraudulently paid benefits are not repaid in full, any purported assignment of benefits may be disregarded by the Plan, and payment of benefits by the Plan under a purported assignment is not a waiver of the right of the Plan to refuse to acknowledge other purported assignments. If any fraudulently paid benefits have not been repaid when a Covered Individual incurs Covered Charges, such Covered Individual shall pay all charges directly and file a claim for credit against amounts owed the Plan in lieu of benefits, until the entire amount owed the Plan has been credited or paid. Any individual who purposefully defrauds the Plan may face criminal prosecution in addition to any civil action taken by the Plan for repayment of improperly paid benefits.

2.9 Information You Must Provide the Plan. For the Plan to provide you the benefits to which you are entitled, you must provide it certain information, as described in this section.

(a) *Change in Dependent Status.* Keep your enrollment form updated by adding a new Spouse, Domestic Partner or Child with any required proof, such as a marriage or Domestic Partner registration certificate, birth certificate or legal adoption papers. You must also notify the Plan Office if a Dependent ceases to qualify as a Dependent, for example, due to divorce, death or the attainment of age 26.

(b) *Change in Beneficiary.* Be sure to complete a beneficiary form for the payment of the Plan's death benefit (see Section 11.7), and keep it current so that family members or others who should be paid your benefits will be paid without unnecessary delay. If you are married or in a domestic partnership, benefits are automatically paid to your Spouse or Domestic Partner unless he or she signs a notarized consent to the designation of some other beneficiary. Consider submitting a new beneficiary designation form if there is a major change in your life circumstance, such as a marriage or divorce.

(c) *Address Change.* Be sure to keep the Plan Office advised of any change in your address. Even if you leave the electrical industry or Local 6 you may continue to receive Plan information about potential future benefits.

2.10 HIPAA Privacy.

(a) *Background.* The Plan's use and disclosure of health information is governed by HIPAA and the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"). Protected health information ("PHI") that is transmitted electronically is "Electronic PHI." The Plan is a "Hybrid Entity" under HIPAA because it provides health benefits and non-health benefits. The rules of this section apply only to health benefits.

(b) *Use and Disclosure of PHI.* The Plan (including EISB) will use PHI and Electronic PHI only to the extent, and in accordance with, the uses and disclosures related to health care treatment, payment for health care and health care operations, and as required by law and permitted by authorization. "Payment" involves Plan activities to obtain premiums or determine or fulfill coverage or benefit responsibilities including, but not limited to, eligibility determinations, enrollment, coordination of benefits, claims adjudication, subrogation, employee contributions, risk adjusting, billing, collection (including reports to consumer reporting agencies related to collection), claims management and related data processing, obtaining payment under a reinsurance contract, reviews of medical necessity, care or charges, and utilization review. "Health care operations" include, but are not limited to, quality assessment, population-based activities to improve health or reduce health care costs, protocol development, case management, care coordination, disease management, communication regarding treatment alternatives, rating providers, rating plan performance, accreditation, certification, licensing, credentialing activities, underwriting, premium rating, creation, renewal or replacement of insurance including reinsurance, stop-loss and excess loss insurance, medical reviews, obtaining legal or auditing services, fraud and abuse detection, business planning, development and management, compliance with HIPAA administrative simplification, customer service, internal grievance resolution and compliance with ERISA (including preparation of required documents such as Forms 5500). The Plan (including EISB) will disclose PHI to the Board only pursuant to an authorization or for Plan administration after receipt of a certification from the Board that this document contains these provisions. Any Trustee that does not comply with these provisions will receive appropriate sanctions. With respect to PHI and Electronic PHI, the Board agrees to:

- not use or further disclose the information other than as permitted or required by the Plan document or law;
- ensure that any agents, including EISB, to whom the Board provides PHI and Electronic PHI agree to these restrictions and conditions;
- not use or disclose the information for employment-related actions or decisions unless the use or disclosure is pursuant to an authorization;
- not use or disclose the information in connection with any other benefit or employee benefit plan unless the use or disclosure is pursuant to an authorization;
- report to the Plan any use or disclosure of the information that the Board is aware of and that is inconsistent with the allowable uses and disclosures;

- make PHI and Electronic PHI available to the individual, for amendment, or for an accounting of non-routine disclosures in accordance with the requirements of HIPAA and HITECH;
- incorporate amendments to PHI and Electronic PHI in accordance with HIPAA and HITECH;
- report to affected individuals a breach of unsecured PHI;
- make internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI received from the Plan available to the Secretary of Health and Human Services for the purpose of determining the Plan's compliance with HIPAA and HITECH;
- ensure that the adequate separation between the Plan and the Board (*i.e.*, the firewall) required by 45 CFR §504(f)(2)(iii) is established; and
- if feasible, return or destroy all PHI and Electronic PHI received from the Plan (or copies) when the information is no longer needed; if not feasible, limit further use or disclosure to the purposes that make the return or destruction infeasible.

The Board further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan, it will:

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- ensure that the firewall required by 45 CFR §504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- appropriately address any security incident of which it becomes aware.

III. EMPLOYEE ELIGIBILITY

3.1 Hour Bank.

(a) *General Rules.* When you begin work in Covered Employment, the Plan will begin to maintain an Hour Bank on your behalf which will be credited (increased) for each hour of Covered Employment you earn, and for which contributions are actually paid to the Trust, based upon the contribution rate of the Collective Bargaining Agreement. An hour of Covered Employment worked in a particular calendar month will be credited on the first day of the second succeeding month in which the month was worked; for example, hours worked in June will be credited effective the following August 1. (See also Section 2.5.) Your Hour Bank may build up to a maximum of 1,000 hours, and any hour to be credited that would cause your Hour Bank balance to exceed 1,000 will not be credited. For each month that you are provided coverage under Sections 3.2 and 3.3, your Hour Bank will be charged (reduced) by 120 hours. You may not purchase Hour Bank credits by making individual contributions to the Plan. The Hour Banks are

not individual bank accounts; they contain no money, have no monetary value, and are entirely subject to the provisions of the Plan.

(b) *Adjustment for Nonstandard Contribution Rate.* If your Employer's contribution rate is different from the Collective Bargaining Agreement contribution rate, the credit to your Hour Bank under subsection (a) may be multiplied by a percentage that results from dividing your Employer's contribution rate by the Collective Bargaining Agreement contribution rate, and then adjusted further for differences in work week or benefit level.

(c) *Cancelation of Hour Bank Balance*

(1) Inactivity. If 12 consecutive months pass without coverage , the balance in your Hour Bank will be canceled. Any future participation in the Plan as a covered Employee will require you to reestablish eligibility under Section 3.2.

(2) Employment with a Noncontributing Employer. If you become employed by an employer in the electrical industry that contributes to no IBEW-sponsored health and welfare plan (including, for example, an Employer that ceases to be obligated under a Contribution Agreement), the balance in your Hour Bank will be immediately canceled.

(d) *Reduction or Elimination of Hour Bank Balance by Board Action.* The existence of an Hour Bank balance reflects your right to receive future coverage under the Plan's existing terms and sufficient funding. Because the Board may, in its sole discretion, reduce, extend or terminate your Hour Bank at any time by written notice to you, your Hour Bank balance provides no vested right to future coverage under the Plan.

3.2 Hours Required for Initial Coverage. To qualify for initial coverage under the Plan, or to re-establish coverage following cancelation of your Hour Bank, you must have accumulated (or re-accumulated) an Hour Bank credit balance under Section 3.1 of at least 300 hours prior to a subsequent cancelation of your Hour Bank account balance in Section 3.1(c)(1). Coverage will be effective on the first day of the second month following the month in which you satisfy the 300-hour requirement. For example, if you begin working (or return to work) in January 2021 and accumulate 300 hours by the end of March 2021, your coverage will become effective May 1, 2021.

3.3 Hours Required to Maintain Coverage. Once you become eligible under Section 3.2 and, subject to the early termination of your coverage under Section 6.6, you will be covered for a later calendar month if your Hour Bank contains a credit balance of at least 120 hours as of the first day of such month (taking into account hours credited as of that day). Except as provided in Section 3.4 (regarding delinquent contributions), 3.6 (regarding disability) and Article IV (regarding Retirees), no coverage will be provided for any portion of a calendar month if your Hour Bank as of the first day of that month does not contain a credit balance of at least 120 hours.

3.4 Limited Coverage Rule for Delinquent Contributions. If hours of Covered Employment fail to be credited to your Hour Bank because your Employer failed to remit the contributions timely (or at all), and if such failure would result in the loss of your coverage under the Plan, you will be provided up to two months of coverage (regardless of your Hour Bank balance) if the Plan Office reasonably determines that your Employer's delinquency would have resulted in your loss of coverage. If payment for past months of lapsed coverage is received by the Plan Office, retroactive insured coverage will be provided to the extent the applicable insurer allows.

3.5 **Reciprocity.**

(a) *General Rules.* To maintain your Hour Bank balance (and therefore qualify for coverage under the Plan), you may apply to have contributions that have been made to another IBEW-NECA sponsored health and welfare plan based on your hours worked (the "Participating Fund") transferred to this Plan and treated as Covered Employment in accordance with procedures set forth in the Reciprocal Agreement. Your application requires that this Plan be your "Home Fund," and you must (i) register on the Electronic Reciprocal Transfer System ("ERTS"), (ii) present a valid photo identification at the Plan Office, the Participating Fund or an assisting IBEW local union, (iii) agree to be bound by your electronic signature on ERTS and (iv) agree to the transfers in such manner as the Reciprocal Agreement and the Plan may require. The effective date of the transfer is the first day of the month in which you have properly registered on ERTS and met the Home Fund eligibility requirements described in subsection (b). The Reciprocal Agreement provides that, upon approval of your application, contributions will be transferred to the Plan to the extent of the lesser of (i) the amount provided in the current Collective Bargaining Agreement or (ii) the amount provided in the current collective bargaining agreement of the Participating Fund. If the Collective Bargaining Agreement's contribution rate is greater than the rate in the Participating Fund's collective bargaining agreement, your credit will be adjusted under Section 3.1(b), except that no adjustment will be made if you are working outside Local 6's jurisdiction under the portability agreement.

(b) *Home Fund Designation.* This Plan is your Home Fund if you are a member of Local 6 in good standing and have been eligible for benefits under this Plan at any time during the past six years. Alternatively, this Plan may be designated as your Home Fund if you (i) are a member of another IBEW local union that is party to the Reciprocal Agreement, (ii) have not been eligible for benefits under your local union's health and welfare plan at any time during the past six years, (iii) have met the eligibility requirements for this Plan, and (iv) have established your intent to return to work under Local 6's jurisdiction as soon as work is available.

(c) *Terminating Reciprocity.* Your approved application under subsection (a) will remain in effect until you execute and submit a cessation of the transfer as required by ERTS. Further information regarding this cessation procedure is available from the Plan Office.

3.6 **No-Cost Disability and Reduced-Cost COBRA Coverage.**

(a) *Disability Defined.* For purposes of this section, you are disabled if (i) you are unable to perform the duties of your regular occupation covered under the applicable Contribution Agreement and (ii) your disability has continued for a period of 30 days. A disability is treated as a continuation of a preceding disability unless it arises from a different or unrelated cause or it is separated by at least three months of continuous Covered Employment.

(b) *No-Cost Coverage for Up to Six Months.* If you become disabled while covered as an Active Employee, your coverage will, upon reduction of your Hour Bank below 120 hours, be continued at no cost to you. This no-cost coverage will cease after six months or, if earlier, either at the end of the month in which you cease to be disabled or after you have been covered for the number of months as you were covered as an Active Employee during the 12-month period preceding the run out of your Hour Bank coverage. If you have less than 7 months of coverage as an Active Employee during the 12-month period preceding the run out of your Hour Bank coverage, Reduced-Cost COBRA Coverage described in subsection (c) below will not be

available. You may, however, continue coverage at the standard COBRA Monthly Coverage Payment amount described in Article VII.

(c) *Reduced-Cost COBRA Coverage for Up to Another Six Months.* After your no-cost disability coverage under subsection (b) has ended, you must elect COBRA Coverage under the rules of Article VII in order to continue Plan coverage. If you continue to be disabled as you begin COBRA Coverage and you have more than 6 months of coverage as an Active Employee during the 12-month period preceding the run out of your Hour Bank coverage, your COBRA Monthly Coverage Payment will be reduced (to the amount described in Appendix B) for up to the first six months of COBRA Coverage. This reduced-cost COBRA Coverage will end earlier if you cease to be disabled, or once the number of your combined months of no-cost disability coverage and reduced cost disability coverage equals the number of months you were covered as an Active Employee during the 12-month period immediately before your no-cost disability coverage began. Once reduced-cost COBRA Coverage ends, you may continue COBRA Coverage at the standard COBRA Monthly Coverage Payment amount described in Article VII.

(d) *Three Month Recovery Extension.* If you cease to be disabled while covered under subsections (b) or (c), and you promptly register for employment under the Collective Bargaining Agreement, you may pay, for up to three months, the same Monthly Coverage Payment that you paid for your most recent month of coverage (either zero for no-cost coverage, or the reduced-cost COBRA Monthly Coverage Payment) until your Hour Bank is sufficient to provide coverage, provided such coverage does not extend beyond the earlier of 12 months or the number of months you were covered during the 12-month period immediately before your no-cost disability coverage began.

(e) *Establishing Disability Coverage.* Evidence of your disability must be submitted to the Plan Office in the form of a written certification of continuing disability by your attending Physician, along with an *Application for Disability Coverage.* The Board may designate a Physician or other medical provider to make the disability determination, and may place additional restrictions on disability coverage. Your application must be submitted no later than 90 days from the last day of your last month of coverage provided by your Hour Bank.

Example: The provisions of this section are illustrated in the following example:

> Participant P began coverage as an Active Employee in October 2021. He becomes seriously ill and ceases work on April 8, 2022, when he has 300 hours in his Hour Bank. He continues to be covered through June 2022 by using 240 hours from his Hour Bank. P then receives no-cost disability coverage from July 2022 through December 2022. P, still recovering from his illness, elects reduced-cost COBRA Coverage beginning January 2023. This reduced-cost coverage is available to P only for January through March 2023 (three months) because his combined no-cost and reduced-cost disability coverage will have then lasted 9 months, the same number of months he was covered before his no-cost disability coverage began (October 2021 through June 2022). Beginning in April 2023, P must pay the full COBRA Monthly Coverage Payment to maintain coverage. However, P recovers in early May 2023 and then returns to work with sufficient hours to provide coverage in July 2023. He continues to pay his full COBRA Monthly Coverage Payment in May and June 2023.

Had P recovered earlier and returned to work or registered for employment under the Collective Bargaining Agreement in November 2022, he would still qualify for reduced-cost

disability coverage through January 2023 (or, if earlier, until he re-establishes eligibility from hours worked) under the 3-month rule, even though he has recovered from this disability.

IV. RETIREE ELIGIBILITY

4.1 Regular Retiree Eligibility.

(a) *General Rule.* If you are a Retiree, you may commence coverage under the Plan as a Regular Retiree if you have attained age 62, this Plan is your Home Plan for retirement purposes, and you satisfy at least one of the following three rules immediately preceding your first month of coverage as a Regular Retiree:

(1) Non-Continuous Coverage Rule. You have received Active Coverage for at least two periods of 12-consecutive months that do not overlap during the most recent 60 months, and you have had Active Coverage for:

(A) at least 120 of the most recent 180 months;

(B) at least 150 of the most recent 240 months and you have retired under the Pension Plan; or

(C) at least 300 months and you have retired under the Pension Plan.

(2) Continuous Coverage Rule. You have been continuously receiving Active Coverage since the date you began work in the electrical industry (disregarding months you did not receive Active Coverage as a result of a reduced work schedule pursuant to a written agreement between the bargaining parties).

(3) Apprentice Rule. You are an enrolled apprentice in a San Francisco Electrical Industry Apprenticeship program.

For purposes of this subsection, any Plan-subsidized period of coverage for disability under Section 3.6 will be treated as Active Coverage. In addition, any month of COBRA coverage you receive before you retire under an IBEW qualified retirement plan (including a defined benefit or defined contribution plan) and while you are registered on Local 6's out-of-work list will be treated as Active Coverage.

(b) *Home Plan.* This Plan is your home plan for retirement purposes if it received more Employer contributions (measured in dollars) with respect to your Covered Employment than the separate health and welfare plan sponsored by IBEW Local 595. For purposes of this section, Active Coverage includes participation in the Electrical Workers Area Health and Welfare Plan (the "Area Plan," which was a predecessor to this Plan that terminated on February 1, 1998). Contributions previously paid to the Area Plan with respect to your Covered Employment will be allocated to the plan in whose jurisdiction your hours of Covered Employment were earned.

(c) *Effective Date of Coverage.* A Regular Retiree becomes eligible for Retiree coverage effective as of the first of the month following submission of a completed application for enrollment, except that Regular Retiree coverage will not begin until the Retiree's Hour Bank balance is insufficient to support further coverage and any existing No-Cost Disability or Reduced Cost COBRA coverage under Section 3.6 has been exhausted.

4.2 Disabled Retiree Eligibility.

(a) *General Rule.* If you are under age 62 and have become totally and permanently disabled while you are receiving Active Coverage or registered on Local 6's "Out of Work" list, you may continue coverage as a Disabled Retiree if:

(1) your Hour Bank balance is insufficient to provide further coverage;

(2) you are no longer eligible for No-Cost Disability or Reduced Cost COBRA coverage under Section 3.6;

(3) you have received Active Coverage for at least 120 of the last 180 months and at least two periods of 12-consecutive months that do not overlap during the 60 months immediately preceding the date of onset of your disability; and

(4) you submit proof of total and permanent disability.

(b) *Totally and Permanently Disabled.* You are totally and permanently disabled if you are unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment that has lasted or can be expected to last for a continuous period of at least twelve months, or can be expected to result in death. The impairment must be so severe as to prevent you not only from engaging in your usual work but, considering your age, education, previous training and work experience, also from engaging in any substantial gainful work which exists in significant numbers in the region in which you live. You must be under the care of a Physician and have been awarded a permanent Social Security disability benefit under Title II of the Social Security Act. Proof that you continue to qualify for Social Security disability benefits and that a Physician considers you to continue to be totally and permanently disabled will be required from time to time by the Plan. A Social Security disability award will constitute a presumption that you are permanently and totally disabled; provided, however, that the presumption may be rebutted by other pertinent facts. If you fail to furnish proof, or if you refuse to be examined by a Physician designated and paid for by the Plan, the presumption of disability will no longer apply, and you will be considered no longer totally and permanently disabled for purposes of this section.

(c) *Effective Date of Coverage.* A Disabled Retiree becomes eligible for Retiree coverage under the rules described in Section 4.1 (relating to Regular Retirees), except that up to 12 months (or such lesser period that would be covered by the benefit option in which the Disabled Retiree is enrolled) of retroactive coverage may be credited to a Disabled Retiree who (i) submits his or her application within 60 days from the date of receipt of a Social Security disability award notice and (ii) makes retroactive monthly payments for such coverage to the date of disability up to twelve (12) months (or such lesser period that would be covered by the benefit option in which the Disabled Retiree is enrolled). Disabled Retiree coverage ends on the last day of the month in which the Disabled Retiree attains age 65 or ceases to be totally and permanently disabled.

4.3 Early Retiree Eligibility.

(a) *General Rule.* You may maintain coverage in the Plan as an Early Retiree if you have attained age 55 and commenced your pension under the Pension Plan, complied with the application deadline, and satisfied the Regular Retiree requirements of Section 4.1(a) as of the date you became a Retiree (except that you have not yet attained age 62).

(b) *Timing of Early Retiree Application.* Your application for Early Retiree coverage must be received by the Plan Office no later than the 60th day following the later of your retirement or the last day of the month for which coverage has been provided from your Hour Bank. If you do not submit a timely application for Early Retiree coverage, your Early Retiree coverage will be permanently forfeited.

(c) *Early Retiree Participation Required if Regular Retiree Service Insufficient.* With one exception, you must participate in the Plan as an Early Retiree if you have not earned sufficient service to qualify for future participation under Section 4.1(a)(1) as a Regular Retiree (assuming a retirement date of age 62). If you do not continue participation, then your coverage under the Plan will end permanently (unless you re-enter Covered Employment). The exception to this rule is explained in subsection (e) below (Pension Plan Rule of 85).

> Example: After 25 years of service, you retire on your 58th birthday and, because of your Hour Bank, you maintain Active Coverage through the month that is one month before your 59th birthday, at which time your Hour Bank balance runs out. Because your Hour Bank balance runs out one month before your 59th birthday, you will be unable to satisfy the requirement in Section 4.1(a)(1) that you be covered as an Active Employee for at least two non-overlapping 12-consecutive month periods as of your 62nd birthday. Therefore, you must continue coverage as an Early Retiree, and pay the required monthly premium, or you will permanently forfeit coverage under the Plan.

(d) *Early Retiree Participation Not Required if Regular Retiree Sufficient.* If you have earned sufficient service to qualify for future participation under Section 4.1(a)(1) as a Regular Retiree (assuming a retirement date of age 62), you are not required to participate as an Early Retiree in order to participate as a Regular Retiree when you attain age 62. However, if you do not participate in the Plan as of the earliest date you may participate as an Early Retiree (generally, immediately after your Hour Bank is exhausted), you may not participate as an Early Retiree, and you must wait to participate as a Regular Retiree at age 62. If you do not submit an application for Early Retiree benefits by the deadline described in subsection (b), you will be deemed to have waived participation as an Early Retiree, though you may later apply for coverage as a Regular Retiree.

> Example: Assume the same facts in the example in subsection (c), except that you maintain coverage as an Active Employee through the month that includes your 59th birthday, at which time your Hour Bank balance runs out. Because your Hour Bank balance runs out after you attained age 59, you will be able to satisfy the requirements in Section 4.1(a)(1) that you be covered as an Active Employee for at least two non-overlapping 12-consecutive month periods as of your 62nd birthday. Assuming you satisfy the other requirements of that section, you may continue coverage as an Early Retiree and pay the required monthly Early Retiree premium, or you may decline coverage as an Early Retiree and re-commence coverage as a Regular Retiree beginning at age 62.

(e) *Pension Plan Rule of 85.* The sole exception to the Early Retiree Participation rule is for Early Retirees who have satisfied the Pension Plan's Rule of 85 at the time the Early Retiree initially commences his or her Early Pension. These Early Retirees may delay Early Retiree participation until age 62 and may pay the lower premium before age 65 that is available to an Early Retiree who has met the Section 4.1(a)(1) service requirements at or after age 59. Under the Pension Plan, you will satisfy the Rule of 85 when your combined age and Pension Credit totals at least 85.

(f) *Special Rule for Non-Inside Wire Electrical Workers.* A Participant who works under a Contribution Agreement that does not require contributions to the Pension Plan (for example, Material Handlers, IBEW Pacific Coast, and Residential Wire agreements) need not satisfy the condition in subsection (a) that benefits under the Pension Plan commence in order to qualify for Early Retiree coverage under this section, provided that the Participant's service would have supported a pension under the rules of the Pension Plan if the service were recognized by the Pension Plan.

(g) *Effective Date of Coverage.* An Early Retiree must commence coverage on the later of (i) the first day of the month following the last month that coverage is available either from the Retiree's Hour Bank or on the basis of the Retiree's No-Cost Disability or Reduced Cost COBRA coverage or (ii) the first day of the month following the month in which the Retiree commences his benefit under the Pension Plan.

4.4 Retiree Monthly Coverage Payments.

(a) *General Rules.* Early Retirees, Disabled Retirees, and Regular Retirees must pay a Monthly Coverage Payment in order to maintain coverage. The Monthly Coverage Payment schedules are included in Appendix B. Generally, Monthly Coverage Payments are adjusted annually on February 1 based on the percentage increases to the Plan following contract renewals with the various Plan insurers. Regular Retiree Monthly Coverage Payments will vary depending upon whether you satisfied the service requirements in the period before attaining age 62 as described in Section 4.3. Depending on your retirement status, Monthly Coverage Payments can be quite expensive, so you may want to review the Monthly Coverage Payment schedule or contact the Plan Office before making your retirement plans. The Board may change, at any time and for any reason, the amount of the Monthly Coverage Payment.

(b) *Making Retiree Monthly Coverage Payment.* A Retiree's Monthly Coverage Payment for a month is due by the 10th day of the month preceding the month of coverage (that is, you must pay in advance of the coverage month). Be sure to make timely payments, because failure to pay your Monthly Coverage Payments on time may result in cancelation of coverage without right of reinstatement. In the case of Early Retirees, failure to timely pay may result in the permanent forfeiture of your Early Retiree coverage and future participation as a Regular Retiree at age 62, unless you satisfy the service requirement under 4.1(a)(1). At your request, your Early Retiree Monthly Coverage Payment may be deducted from your monthly Pension Plan benefit. Contact the Plan Office for the form that authorizes the deduction from your pension check.

4.5 Medicare.

(a) *Overview.* Medicare is the health insurance program for people age 65 or older, certain people with disabilities who are under age 65, and individuals with permanent kidney failure. Medicare Part A is hospital insurance, Medicare Part B is insurance for physician services, out-patient care, durable medical equipment, home health services and other medical services, Medicare Part C is a private insurance program called Medicare Advantage (which generally allows HMOs to cover Medicare-eligible individuals at a lower cost to the HMO), and Medicare Part D is insurance for pharmacy benefits. Medicare Part A is primarily financed by payroll taxes, while Parts B, C and D are financed primarily by premiums paid by those who choose to enroll. For enrollment and eligibility information, call Social Security at (800) 772-1213 and check the Internet at medicare.gov. Generally, if you are receiving Active Coverage, you are not required to enroll in Medicare in order to continue to participate in the Plan. If you are a Retiree and wish to

continue to participate in the Plan, you must enroll in Medicare, as explained in subsection (b), and you may select from the Self-Funded PPO or Kaiser HMO benefit options described in Section 6.1.

(b) *Retirees in Self –Funded Plan Must Enroll in Parts A and B.* If you are a Medicare-eligible Retiree who is enrolled in the Self-Funded PPO, you must enroll in Medicare Parts A and B. The Plan will pay your medical claims on the assumption that you have full Medicare coverage under Parts A and B, regardless of whether you have actually enrolled for the full coverage. So, failing to enroll in Medicare Parts A and B will result in you having to pay substantially higher out-of-pocket costs for health care services, including increased premiums. The same rule applies for your Medicare-eligible Dependent, unless your Dependent continues working and has health care benefits through his or her own employer's group health plan. If your Medicare-eligible Dependent continues working but has Retiree coverage under this Plan through you, then he or she must enroll in Parts A and B when you enroll in these programs or else risk increased Medicare premiums. Out-of-pocket charges resulting from failure to enroll in Medicare Parts A and B will not apply towards your maximum calendar year out-of-pocket limit under Section 8.6(c).

(c) *Retirees in Kaiser HMO Must Enroll in Part C.* If you are a Medicare-eligible Retiree who is enrolled in the Kaiser HMO, you must enroll in your HMO's Medicare Part C program as soon as you are eligible. If you do not enroll, you will pay the difference between the regular (non-Part C) premium charged to the Plan by the HMO over the significantly lower Part C premium that the Plan would have been charged by the HMO. Blue Shield does not have a comparable Part C Plan. If you are enrolled in the Blue Shield HMO at the time you become eligible for Medicare, you will be transferred to the Self-Funded PPO unless you choose to be enrolled in the Kaiser Senior Advantage Plan.

(d) *Part D Prescription Drug Program.* Medicare-eligible Retirees are eligible for a prescription drug program under Medicare Part D and are automatically enrolled by the Plan and will be charged a premium by Medicare. Retirees covered under the Self-Funded PPO or an HMO are not covered under the Plan's prescription drug plan. While the Plan has automatically enrolled in Medicare Part D, you still must enroll in both Medicare Parts A and B to receive full coverage in the Plan.

(e) *End-Stage Renal Disease.* If you are diagnosed with End-Stage Renal Disease ("ESRD"), you may be eligible for Medicare. If you are eligible for Medicare due to ESRD, you must apply to receive full benefits because enrollment for Medicare benefits is not automatic. This Plan coordinates ESRD benefits with Medicare. If you do not enroll in Medicare as soon as you are eligible, the Plan will not cover the portion of your expense that Medicare would have paid. As soon as you are eligible for Medicare, please enroll and notify the Plan Office immediately.

4.6 Supplemental Benefits Available Even if No Major Medical Coverage. Covered Individuals who are enrolled in Medicare (other than Part D) and not enrolled in either the Self-Funded PPO or Kaiser HMO described in Section 6.1 may elect to receive solely the supplemental benefits described in Article XI.

4.7 Suspension/Cancelation of Retiree Benefits.

(a) *Prohibited Employment Causes Suspension or Cancelation of Coverage.* If you are a covered Retiree, your coverage under the Plan will be suspended for any month that your benefit under the Pension Plan is suspended (or would have been suspended, if your Pension Plan benefit has not yet commenced or you worked under a Collective Bargaining Agreement that does not

require contributions to the Pension Plan) because you engage in what is (or would be, if your Pension Plan benefit has not yet commenced) prohibited employment by returning to work in the electrical industry. Whether employment is prohibited employment shall be determined by the Board by applying the standards set forth in the Pension Plan, and that determination is subject to all of the procedural rules of the Pension Plan. If you return to work in prohibited employment for a non-contributing employer as a Retiree, your coverage under the Plan will be terminated permanently, and you will forfeit all future coverage under the Plan based on your past service (including as a Regular Retiree). To the extent that it is determined that the prohibited employment giving rise to the suspension was based on a material misrepresentation or intended to defraud the plan, you will also be obligated to reimburse the Plan for any benefits paid on your or your family's behalf during any period of such prohibited employment. Refer to the Pension Plan's summary plan description for further information about prohibited employment or contact the Plan Office for further information.

(b) *Returning to Covered Employment May Reestablish Active Coverage*

(1) Suspended Pension Plan Benefits. If you are a covered Retiree who returns to Covered Employment and reestablishes eligibility under Section 3.3, then you will cease participation as a Retiree and re-commence participation as an Active Employee.

(A) *Early Retiree Participation Required.* If you have not earned sufficient service to qualify for future participation under Section 4.1(a)(1), as a Regular Retiree (assuming a retirement date of age 62) and you become eligible for Active Coverage based on your work hours, you will not be required to continue to pay Early Retiree Monthly Coverage Payments under Section 4.4 unless you subsequently retire prior to age 62. In that event, you will be required to make continuous Early Retiree Monthly Coverage Payments when Active Coverage ends in order to qualify for Regular Retiree Coverage.

(B) *Early Retiree Participation Not Required if Regular Retiree Sufficient.* If you have earned sufficient service to qualify for future participation under Section 4.1(a)(1) as a Regular Retiree (assuming a retirement date of age 62), you are not required to make continuous Early Retiree Monthly Coverage Payments when Active Coverage ends in order to participate as a Regular Retiree when you attain age 62. However, failure to do so will waive any rights to continue coverage as an Early Retiree.

(2) Non-Suspended Pension Plan Benefits. If you are a covered Retiree who returns to Covered Employment and your Pension Plan benefits are not suspended because you work fewer than 40 hours per month, there will be no change to your coverage as a Retiree, nor will there be a reinstatement of an Hour Bank for Active Coverage.

V. DEPENDENT ELIGIBILITY

5.1 Dependent Coverage. All Dependents of a Participant are eligible for coverage under the Plan subject to the rules of this article. You must notify the Plan Office immediately if any individual ceases to be your Dependent. Initial and updated enrollment information, including proof of the continued existence of Dependent status, must be furnished to the Plan Office from time to time as requested. Your Dependent's coverage may be suspended if required information has not been submitted to the Plan Office upon request.

5.2 Dependent Coverage upon Death of Participant. Upon a Participant's death, the Participant's surviving Dependents will continue to be covered until the Participant's Hour Bank (if any) has been exhausted. If the Participant dies while a Regular or Disabled Retiree, the Participant's Dependents will remain eligible for Plan coverage after the Participant's death. If the Participant died before becoming a Regular or Disabled Retiree, then the Participant's Dependents will be eligible for coverage if the Participant would have met the requirements for Regular Retiree coverage contained in Section 4.1, determined without regard to the age 62 requirement. The surviving Dependents (as a family unit) must pay Retiree Monthly Coverage Payments as described in Section 4.4, though the Board may establish a separate premium level for surviving Dependents. Coverage of a surviving Spouse or Domestic Partner will cease upon the Spouse's or Domestic Partner's remarriage.

5.3 Qualified Medical Child Support Orders. The Plan will extend benefits to a Participant's non-custodial child, as required by any qualified medical child support order ("QMCSO") under ERISA §609(a), including a National Medical Support Notice described in ERISA Regulation §2590.609-2. The Plan has procedures for determining whether an order qualifies as a QMCSO, which any Covered Individual can obtain from the Plan Office.

5.4 Establishing Tax Dependent Status. Generally, only dependents who qualify under the Internal Revenue Code as a spouse or tax dependent may be covered under the Plan without the coverage being taxable to the Participant for federal income tax purposes. 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.

5.5 Imputed Income for Certain Dependents.

(a) *Imputed Income if Plan Provides Coverage of Non-Dependent.* In general, the value of health coverage provided to a spouse or child of a Participant is not taxable to the Participant (or to the spouse or other dependent). Unless your Domestic Partner can be treated by the Plan as your spouse or dependent under the tax code, the value of any employer-paid coverage provided to your Domestic Partner will be treated as taxable income to you and reported on your Form W-2. This income is often referred to as "imputed income." The Plan must report the imputed income and withhold certain payroll taxes from you, such as social security and income tax withholding. At the end of the year, you will receive a supplemental federal Form W-2 showing income and payroll tax withholdings that would not have been reported had no non-dependent Domestic Partner or child coverage been provided.

(b) *After-Tax Contributions if Employee Pays for Coverage of Non-Dependent.* To the extent you pay the premium for your Domestic Partner (or his or her child) through a Monthly Coverage Payment, no imputed income for non-tax Dependent coverage will be reported on your Form W-2.

(c) *Dependent Status.* In general, you can claim your Domestic Partner as a dependent for purposes of your tax return if, for the entire year, your partner:

(1) has the same principal place of abode as you;

(2) is a member of your household;

(3) is a resident of the U.S., Canada or Mexico, or is a citizen of the U.S.;

(4) receives over half of his or her financial support from you; and

(5) has income of less than the exemption amount of $4,300 (for 2021).

The income requirement in (5) above, however, does not apply when determining whether your Domestic Partner is taxed on the value of coverage provided by the Plan. Therefore, it is possible that your Domestic Partner does not qualify as your tax dependent for purposes of filing your federal income tax Form 1040 (for example, if your partner had income exceeding the exemption amount) but is nonetheless your tax dependent for purposes of the Plan and eligible to receive tax-free coverage under the Plan. If you believe you might provide more than half of the support for your Domestic Partner, you may wish to use the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information) before you certify tax dependent status to the Plan.

(d) *Certification.* If your Domestic Partner qualifies as a Dependent under the Plan, you must provide a Certification of Tax Dependency form if you wish to have the Plan recognize your partner's dependent status. You will be asked to complete this certification annually for the following year, subject to any change in status that may occur during the year. As a condition to your Domestic Partner's participation in the Plan, you are required to notify the Plan Office immediately if your partner fails to satisfy any of conditions (1) through (4) above in subsection (c) during a year that the Plan is treating your partner as a tax dependent. By enrolling your non-dependent Domestic Partner (or his or her child) in the Plan, you also are agreeing to pre-pay any payroll-related taxes attributable to your imputed income. Failure to satisfy the annual certification requirement or pre-payment of any payroll related taxes will result in loss of coverage to the Domestic Partner and subject to reinstatement under Sections 6.3 and 6.4.

(e) *When Dependency Status is Determined.* The requirements for determining dependency status are determined as of the end of a year and must be met for that entire year. Thus, for example, if your Domestic Partner became a member of your household during October 2021, the same month that you certify your Domestic Partnership, your partner would not be a Dependent under the Plan for any of 2021. Although, in that case, your Domestic Partner may be enrolled in the Plan during the 30-day period beginning on the date of your domestic partnership, coverage of your partner would not be tax-free until 2022, and then only if all of conditions (1) through (4) of subsection (c) mentioned above are satisfied for all of 2022.

(f) *Children of Domestic Partner.* The child of your Domestic Partner may enroll in the Plan if treating your Domestic Partner as your spouse would result in the child's eligibility for Plan coverage. The child of your Domestic Partner, who is not also your child, will generally not qualify for tax-free health coverage because federal tax law generally prevents a plan participant (who is not the original parent) from claiming a child as a dependent if that child can be claimed as a tax dependent by the participant's Domestic Partner or by the child's other parent. If you believe that the child of your Domestic Partner qualifies for tax-exempt health coverage under the Plan, please contact the Plan Office. We suggest that you consult your tax advisor for the information needed to make this determination.

VI. ENROLLMENT AND TERMINATION OF COVERAGE

6.1 Benefit Options. The Plan's medical benefits are offered through three options:

(1) the Self-Funded PPO, where the Plan pays a fee to Blue Shield for the use of Blue Shield's Shared Advantage preferred provider network, which includes mental health through Magellan and substance abuse benefits as described in section 8.7(e)

through Beat It, and where the Plan contracts with OptumRx for prescription drug benefits as described in Section 8.5(a);

(2) the Blue Shield HMO, where the Plan pays a premium to Blue Shield of California for coverage under its HMO; and

(3) the Kaiser HMO, where the Plan pays a premium to Kaiser Health Plan, Inc. for coverage under its HMO.

The HMO benefits are explained in Article IX. Separately, the Plan offers benefits under a health reimbursement arrangement (HRA – Article X), supplemental dental benefits (Section 11.1), vision care benefits (Section 11.2), long-term disability benefits (Section 11.3), supplemental parental leave benefits (Section 11.4) and death benefits (Section 11.7).

6.2 Initial Enrollment. Because Plan benefits are available to you without cost, you and all of your Dependents will ordinarily want to enroll in the Plan. When enrolling in the Plan for the first time, you will select one of the three major medical coverage options described in Section 6.1. You and your Dependents should review the Plan Comparison Worksheets and Summary of Benefits and Coverage when deciding which option would best meet your needs. The Plan Office provides these documents prior to initial eligibility and make them available on the EISB.org website. If you do not select one of these options on your enrollment form, or if you do not submit an enrollment form, you will automatically be enrolled in the Self-Funded PPO. However, if you wish to opt out of the Plan for whatever reason, please contact the Plan Office and request a form on which you may elect to be excluded from Plan coverage. No compensation will be paid to you if you choose not to be covered under the Plan.

6.3 Rolling Open Enrollment. This Plan has a rolling open enrollment arrangement which allows you to change benefit options anytime during the year, so long as you have not made an election change in the 12 months that precede the effective date of the change. Exceptions are available for those participants who move out of the Kaiser or Blue Shield HMO service area. In addition, special enrollment rules will still apply. (See Section 6.4 below.) Be sure to enroll all of your Dependents when you first enroll. If you do not enroll a Dependent when you first enroll, your Dependent may later be enrolled only under the Special Enrollment provisions in Section 6.4 or in 12 months during a succeeding open enrollment opportunity.

6.4 Special Enrollment. You may enroll a Dependent at a time other than your initial or rolling open enrollment under the following circumstances:

(1) if you marry or enter into a domestic partnership, you may enroll your new Spouse or Domestic Partner within 30 days of your marriage or domestic partnership;

(2) if you have a Child by birth, adoption or placement for adoption, you may enroll your new Child within 30 days of the Child's birth, adoption or placement for adoption;

(3) if your un-enrolled Dependent loses other health insurance coverage, you may enroll that Dependent in the Plan within 30 days of the date that the other coverage ends; and

(4) if you lost coverage due to an insufficient Hour Bank balance, then later reestablished coverage under Section 3.2 after earning additional hours of Covered Employment, you may enroll any un-enrolled Dependent during the 30-day period beginning on the first day of the month for which your coverage is reestablished.

The special enrollment rules of this section shall be applied consistent with the provisions of Treasury Regulation §54.9801-6 (except as expressly modified otherwise).

Exception. There is a $100 penalty for Participants who fail to add or reinstate Dependents within 30 days; however, retroactive application is limited to the time period the insurer would permit retroactivity.

6.5 Retiree's and Retiree Dependents' Opt-Out and Re-Enrollment Right. If you are a Disabled or Regular Retiree or a Dependent of a Retiree who wishes to dis-enroll from coverage under the Plan, you may exercise a one-time option to dis-enroll from Plan coverage with a right to re-enroll during a subsequent rolling open enrollment opportunity, provided you submit evidence of minimum value, minimum essential, coverage (as defined under the ACA) continuously for the twelve-month period immediately prior to re-enrollment in the Plan.

Pension Plan Rule of 85. Any retiree who satisfies the Pension Plan Rule of 85 as of retirement date (or re-retirement date for any participant who satisfies the Rule of 85 after working in Prohibited Employment) will be allowed to opt out of coverage for one continuous period of any length through the month in which the retiree attains age 62, provided that the retiree can demonstrate continuous group or individual minimum essential coverage, of at least minimum value, from retirement (or re-retirement) date until age 62 for all family members for whom retiree coverage is to be provided.

6.6 Termination of Coverage. Coverage under the Plan will terminate for Covered Individuals as follows:

(1) upon exhaustion of the Participant's Hour Bank balance (or charging of hours below 120) as provided in Section 3.2 (for the Participant and Dependents);

(2) upon nonpayment, or untimely payment, of a required Monthly Coverage Payment (for the Participant and all Dependents, effective immediately before the first day of the month for which the payment would have applied);

(3) upon the adoption of any Plan amendment that terminates the Covered Individual's coverage (as the amendment provides);

(4) upon the first date on which the Participant works in the electrical industry that is not Covered Employment (for the Participant and Dependents);

(5) if and when the Participant fails to maintain membership in good standing in IBEW Local 6 (for the Participant and Dependents);

(6) when a Dependent ceases to qualify as a Dependent (for the Dependent only, effective at the end of the month);

(7) upon the Participant's death (as provided in Section 5.2);

(8) upon the Participant's Retirement (for the Participant and Dependents, except as coverage may be available under Article IV);

(9) the date any family member enrolls in a Medicare Part D program outside this Plan (as provided in Section 4.5(d));

(10) upon the failure of any Covered Individual to abide by the Plan's provisions (such as the commission of fraud or material misrepresentation) that results in a forfeiture of coverage (for the Covered Individual and his or her covered Dependents, effective immediately); and

(11) upon affirmative disenrollment by the Participant.

6.7 Family and Medical Leave Act. If you take family medical leave from your Employer as allowed under the Family and Medical Leave Act of 1993 ("FMLA") or the California Family Rights Act of 1993 ("CFRA"), coverage will be continued during the leave. Any Hour Bank reserve standing to your credit shall be frozen as of the last day of the month in which your leave begins. Your Employer will continue to remit contributions to the Plan as required under the Contribution Agreement until your family medical leave expires (generally, 12 work weeks), you return to Covered Employment or you register at Local 6's dispatch hall. Your Hour Bank will be unfrozen on the earlier of (i) the first of the month immediately succeeding the month in which you return to Covered Employment (or register with Local 6) or (ii) the date your family medical leave expires. Upon termination of leave benefits, you may continue (or recommence) coverage under the Plan as your Hour Bank balance permits, and otherwise as the Plan allows.

6.8 Military Service.

(a) *General Rules for Continued Coverage.* If you are an Active Employee and called to active military service in the Uniformed Services of the United States ("Military Service"), you are entitled to continue coverage in the Plan for up to 24 months if you qualify for such coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). The "Uniformed Services" means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States of America in time of war or emergency. You must give prior notice (oral or in writing) to your Employer that your absence will be due to participation in a Uniformed Service. We request that you also notify the dispatch office of Local 6 and the Plan Office so that the Plan is aware that your coverage should be maintained.

(b) *Purchase of Coverage.* If you are absent from Covered Employment to perform Military Service for less than 31 days, you may continue your coverage under the Plan without charge. If you are absent from Covered Employment to perform Military Service for more than 30 days, you may elect to purchase coverage for up to 24 months (the first month of which is at no charge to you) for a Monthly Coverage Payment equal to the applicable monthly COBRA premium. Although USERRA coverage described in this section is not COBRA Coverage, your absence for military service will also trigger election rights under COBRA, and you may elect continued coverage under whichever of the two options provide you the most favorable benefit.

(c) *Hour Bank Frozen if Requested.* Your Hour Bank will be frozen effective with the first of the month following the month that Plan coverage is provided from your Hour Bank before entering Military Service. For example, if you last worked in Covered Employment, and you entered Military Service, in January, your January hours will be credited to your Hour Bank on March 1 and your account will then be frozen on that date. Your April coverage will be provided to you without charge to your Hour Bank. If you wish to continue coverage after April for up to the additional 23 months, you may either (i) pay the Monthly Coverage Payment described in

subsection (b) to the Plan Office or (ii) elect to apply hours in your Hour Bank balance to continue coverage as long as your Hour Bank will allow. When you return to Covered Employment (with proper notice and documentation), you may recommence coverage subject to your Hour Bank balance.

VII. COBRA COVERAGE

7.1 General Rules. The Consolidated Omnibus Budget Reconciliation Act of 1985 (the federal law known as "COBRA") generally gives you and your Dependents the right to purchase Plan coverage for a temporary period upon a loss of coverage by reason of a "Qualifying Event." A "loss of coverage," for this purpose, means any continuation of coverage under the Plan on terms less favorable than coverage that applied immediately before the Qualifying Event (such as requiring a Monthly Coverage Payment where none was previously required). Timely Monthly Coverage Payments must be made to the Plan Office in the amount indicated in Appendix B. The maximum Monthly Coverage Payment will generally be the Plan's cost to provide your coverage (either by paying an insurance premium to one of the HMOs or by covering your claims directly under the Self-Funded PPO) plus a 2% administrative charge, except that the COBRA Monthly Coverage Payment for months (after the first 18 months) due to total disability will include a 50% surcharge instead of 2%. The Board may set the COBRA Monthly Coverage Payment at a lesser amount in its discretion.

(a) *Reduced Monthly Coverage Amount for Apprentices.* An apprentice in good standing who has made a COBRA Coverage election may pay a reduced Monthly Coverage Payment for COBRA Coverage for a month that is equal to the hourly Plan contribution rate under the Collective Bargaining Agreement multiplied by the number of hours that the apprentice's Hour Bank balance is deficient for providing coverage for that month. For this purpose only, the apprentice's Hour Bank balance shall include the number of day class hours attended by the apprentice during the month preceding the month for which the Monthly Coverage Payment applies. This rule is available to an apprentice only if the Director of Apprentice Training certifies to the Plan Office that the apprentice is eligible for this special rule.

(b) *Reduced Monthly Coverage Amount for Disabled Participants.* Disabled Participants may qualify for a reduced cost Monthly Coverage Amount for a limited portion of their maximum COBRA coverage period. (See Section 3.6.)

7.2 COBRA Events, Beneficiaries and Maximum Coverage Periods. COBRA Coverage under the Plan will be provided in accordance with the following table:

Qualifying Event	Qualified Beneficiary	Maximum Coverage Period
Termination of Covered Employee's Covered Employment (other than for gross misconduct), or reduction in hours of employment, resulting in a loss of coverage	Employee and Dependents	18 months after loss of coverage
Death of Participant	Dependents	36 months after loss of coverage

Divorce of Participant	Former Spouse or Domestic Partner	36 months after loss of coverage
Dependent ceases to qualify as Dependent	Applicable Dependent	36 months after loss of coverage

If you are on COBRA Coverage because of termination of Covered Employment or reduction in hours, you can extend coverage if a second qualifying event occurs during the initial 18-month period. The maximum period of COBRA Coverage may not exceed 36 months from the loss of Coverage. For example, should you die after 6 months of COBRA Coverage resulting from your termination of employment, your Dependents may qualify for a total of 36 months of COBRA Coverage.

If your Spouse, Domestic Partner or Child is not covered under the Plan at the time you experience a COBRA qualifying event, they will not be eligible for COBRA coverage.

(a) *Disability Extension.* If a Covered Individual is determined by the Social Security Administration to be disabled and the Plan Office is provided timely notice of the determination, all of the Covered Individual's covered family members may be entitled to receive up to an additional 11 months of COBRA Coverage, for a maximum of 29 months. This extension is available only for Covered Individuals receiving COBRA Coverage because of the Participant's termination of employment or reduction of hours. The disability must have started during the 60-day period beginning on first day of COBRA Coverage and must last at least until the end of the period of COBRA Coverage that would be available without the disability extension (generally 18 months).

7.3 <u>COBRA and Medicare</u>. If a covered Employee has a Qualifying Event due to termination of employment or reduction in work hours, and the Qualifying Event occurs less than 18 months after the date the Employee became entitled to Medicare, then the maximum COBRA Coverage period for the Employee's Dependents is extended to the last day of the 36-month period beginning on the date the Employee became entitled to Medicare, while the maximum period of COBRA Coverage for the covered Employee is 18 months from the Qualifying Event. If a covered Employee has a Qualifying Event due to termination of employment or reduction in work hours and, after the Employee has elected COBRA Coverage and during the first 18 months of such coverage, the Employee first becomes entitled to Medicare, the Employee's COBRA Coverage will end. However, COBRA Coverage with respect to the covered Employee's Dependents who have elected COBRA Coverage will not be terminated due to the Employee's entitlement to Medicare and may continue through the remainder of the 18-month maximum coverage period.

In general, if you don't enroll in Medicare Part A or B during the initial enrollment period when you are first eligible because you are still employed, after the initial enrollment period you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you

want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first as the primary payer and COBRA continuation coverage will pay second as the secondary payer. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For purposes of this article, "entitled to Medicare" means (i) enrollment in Medicare Parts A or B or (ii) having ESRD and (a) having applied for Medicare Part A, (b) having satisfied any waiting period requirement and (c) being either (1) insured under Social Security, (2) entitled to retirement benefits under Social Security or (3) a spouse or dependent of an individual satisfying either (1) or (2).

7.4 Separate Notice Required by Dependent. If a Dependent loses, or will lose, Plan coverage due to the event of divorce, legal separation or ceasing to be a Dependent, such Dependent or the covered Employee must notify the Plan Office within 60 days of the event in the manner prescribed by the Plan's COBRA notice procedures. Failure to provide timely notice will result in a termination of the Dependent's COBRA rights under the Plan. A Dependent must notify the Plan Office of the birth, adoption or placement for adoption of a child while receiving COBRA Coverage, also as required by the Plan's COBRA notice procedures.

7.5 COBRA Notice Procedures. The Plan has established procedures to notify covered Employees and Dependents of all required notice events under COBRA, including an initial notice that provides an overview of the COBRA rules to a new Participant and instructions for paying the Monthly Coverage Payment. Should you have any questions regarding your COBRA rights, please request a copy of the initial notice from the Plan Office, or otherwise discuss your questions with the Plan Office.

7.6 Early Termination of COBRA Coverage. COBRA Coverage will terminate before the maximum period set forth in Section 7.2 on:

(1) the date of the Plan's termination with no successor plan;

(2) the last day of the month for which Monthly Coverage Payments have been made;

(3) the date the Qualified Beneficiary, after having elected COBRA Coverage, first becomes enrolled in Medicare;

(4) the date the Qualified Beneficiary, after having elected COBRA Coverage, first becomes covered under another group health plan;

(5) in the case of a disabled Qualified Beneficiary (and Qualified Beneficiary family members) receiving COBRA Coverage under the 11-month extended coverage (months 19 through 29) described in Section 7.2, the first day of the month that begins more than 30 days after the date the Qualified Beneficiary is determined by the Social Security Administration to no longer be "disabled" within the meaning of the Social Security Act; or

(6) the date the Participant's Employer ceases to be an Employer.

7.7 Coverage Options. A Participant with a COBRA Coverage election may elect either core coverage only or both core and non-core coverage. "Core coverage" is major medical coverage only. "Non-core coverage" is dental and vision care coverage, and must be elected together if at all. Non-core coverage cannot be elected without core coverage.

7.8 California COBRA. Under California law, the Kaiser HMO and the Blue Shield HMO must offer to continue HMO coverage for certain Covered Individuals beyond the maximum coverage period described in Section 7.2. Please contact Kaiser or Blue Shield for more information for this extended continuation coverage. A Covered Individual in the Self-Funded PPO is not eligible for this extended coverage.

VIII. SELF FUNDED PPO OPTION

8.1 In General. The Self-Funded PPO pays your Covered Charges (as defined in Section 8.9) directly from Plan assets. Blue Shield provides PPO administrative claims payment services for Covered Charges other than prescription drugs as provided in Sections 8.2 and 8.3, and OptumRx provides PPO administrative claims payment services for prescription drug Covered Charges as provided in Section 8.9 Neither Blue Shield nor OptumRx assumes any financial risk or obligation with respect to claims.

8.2 Blue Shield California PPO Network. A "Preferred Provider" is a Physician, Hospital, ambulatory surgery center, certified registered nurse anesthetist, participating dialysis center, home health care agency or home infusion agency (including hospice services in accordance with Medicare Guidelines) that has contracted with the Plan or its delegate (in the Plan's case, Blue Shield) to furnish services and to accept the Plan's payment, along with any deductibles and coinsurance, as full payment for covered services. The Plan's major California medical Preferred Provider organization network (or "PPO") is the Blue Shield Shared Advantage Program. It provides for the payment of Covered Charges rendered by in-network providers at predetermined fees. Neither the Participant nor the Plan is responsible for any charges in excess of the contracted amount. Some services not normally covered under the Plan may be included at no charge at a PPO network facility. Information regarding the Self-Funded PPO program, and a schedule of Preferred Providers, is available by contacting the Plan Office or through Blue Shield's website at blueshieldca.com. With the exception of certain charges identified as subject to the No Surprises Act, described below in Section 8.4 below, when you use out-of-network providers, payment is limited to Reasonable and Customary Covered Charges, and you must pay any charges that exceed the Reasonable and Customary amount in addition to the annual deductible and any coinsurance. Therefore, you may have substantially higher out-of-pocket expenses when you use out-of-network providers. Charges that exceed the Reasonable and Customary amount will not be applied to the deductible, any coinsurance, or the out-of-pocket maximum.

8.3 Blue Shield Out of State Programs.

(a) *General Rules.* Benefits will be provided for Covered Charges received outside of California within the United States, Puerto Rico and the U.S. Virgin Islands. The Plan calculates the Covered Individual's coinsurance as a percentage of the allowable amount, as provided in Section 8.6(b). When Covered Charges are incurred in another state, the Covered Individual's coinsurance will be based on the local Blue Cross and/or Blue Shield plan's arrangement with its providers under the BlueCard program described in subsection (e). Blue Shield has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their licensed controlled affiliates ("Licensees"). Whenever you obtain healthcare services outside of California, the claims for these

services may be processed through one of these inter-plan programs, which includes the BlueCard Program. When you incur Covered Charges outside of California you may obtain care from participating providers with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (the "Host Plan").

(b) *Services Obtained from Non-Preferred Providers.* In some instances, you may obtain care from out-of-state non-preferred healthcare providers within the U.S., Puerto Rico or the U.S. Virgin Islands. If you do not see a participating provider through the BlueCard Program, you must pay the entire bill for your medical care and submit a claim form to the local Blue Cross and/or Blue Shield plan or to the Plan Office for payment. The Plan Office will notify you of its determination within 30 days after receipt of the claim. The Plan Office will pay you at the non-Preferred Provider benefit level. Remember, your coinsurance is higher when you use a non-Preferred Provider. You will be responsible for paying the entire difference between the amount paid by the Plan and the amount billed. Charges for services that are not covered, and charges by non-Preferred Providers in excess of the amount covered by the Plan, are the Participant's responsibility and are not included in coinsurance calculations.

(c) *How to Access Out-of-State Services in U.S., Puerto Rico and U.S. Virgin Islands.* When you require covered services while traveling outside of California, but within the U.S., Puerto Rico and the U.S. Virgin Islands:

(1) call BlueCard Access® at (800) 810-BLUE (2583) to locate Physicians and Hospitals that participate in the local Blue Cross and/or Blue Shield plan, or go online at bcbs.com and select the "Find a Doctor or Hospital" tab; and

(2) visit the participating Physician or Hospital and present your membership card.

The participating Physician or Hospital will verify your eligibility and coverage information by calling BlueCard Eligibility at (800) 676-BLUE. Once verified and after services are provided, a claim is submitted electronically and the participating Physician or Hospital is paid directly. You may be asked to pay for your applicable coinsurance and deductible at the time you receive the service. You will receive an Explanation of Benefits which will show your payment responsibility. You are responsible for the coinsurance and deductible amounts shown in the Explanation of Benefits. Prior authorization is required for all non-emergency in-patient Hospital services; however, only notification is required for in-patient emergency services. Prior authorization is required for selected in-patient and out-patient services, supplies and durable medical equipment. To receive prior authorization from the Plan, the out-of-area provider should call the customer service number noted on the back of your identification card. If you need emergency services, you should seek immediate care from the nearest medical facility. Plan benefits will be provided for covered services received anywhere in the world for emergency care of an illness or injury.

(d) *Care for Covered Urgent Care and Emergency Services Outside the United States.* Benefits will also be provided for covered urgent and emergent services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you need urgent care while out of the country, call the BlueCard Worldwide Service Center at either the toll-free BlueCard Access number (800) 810-2583 or collect (804) 673-1177, 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires precertification or prior authorization, you should also call the Plan at the customer service number noted on the back of your identification card. For in-patient hospital care, contact the BlueCard Worldwide Service

Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-Covered Charges, deductibles, and coinsurance). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim to the BlueCard Worldwide Service Center. When you receive services from a physician, you will have to pay the doctor and then submit a claim. Before traveling abroad, call your local Customer Service office for the most current listing of providers world-wide or you can go on-line at bcbs.com and select "Find a Doctor or Hospital" and "BlueCard Worldwide."

(e) *BlueCard Program.* Under the BlueCard Program, when you obtain covered services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant's liability (such as coinsurance and deductibles). However, the Host Plan is responsible for contracting with and generally handling all interactions with its participating healthcare providers. The BlueCard Program enables you to obtain covered services outside of California, as defined, from a healthcare provider participating with the Host Plan, where available. The participating healthcare provider will automatically file a claim for the covered services provided to you, so there are no claim forms for you to fill out. You will be responsible for any member coinsurance and deductibles, if any, as stated in this document. Whenever you incur Covered Charges outside of California and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of (i) the billed Covered Charges for your covered services or (ii) the negotiated price that the Host Plan makes available to Blue Shield. Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or under-estimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Plan uses for your claim because they will not be applied retroactively to claims already paid. Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Charges according to applicable law. Claims for covered services are paid based on the Reasonable and Customary amount. See Appendix D for details.

8.4 No Surprises Act: Certain Out-of-Network Charges Cost-Sharing Same As In-Network/ PPO. Certain out-of-network charges, including emergency, specific non-emergency services rendered in an in-network facility, and air ambulance services will be identified by the Plan as being subject to the No Surprises Act ("NSA"), a federal law intended to protect consumers from surprise bills by healthcare providers. For NSA charges, the Plan will calculate and, as appropriate, negotiate the payment amount with the out-of-network provider in an amount substantially similar to the Plan's contracted in-network rate for the same services.

Unless you affirmatively consent to waive the applicability of the NSA, you will be subject to the same cost-sharing requirements for these NSA charges as if the claim was provided by a PPO

provider and will not be responsible for any charges in excess of the contracted amount, including any "balance bill" that might otherwise be required by an out-of-network provider.

8.5 Prescription Drug Card Program.

(a) *Administered by OptumRx.* The prescription drug card program for Covered Individuals under the Self-Funded PPO is administered by OptumRx, which is a pharmacy benefit manager.

(1) OptumRx Identification Cards. Shortly after you become eligible, OptumRx will provide you an identification card that you must present at a network pharmacy each time you purchase a prescription. You may order additional cards by calling OptumRx at (888) 354-0090 or (800) 356-3477.

(2) OptumRx Participating Pharmacies. Most major chains and independent pharmacies are in the OptumRx pharmacy network, including Lucky, Costco, K-Mart, CVS, Raley's, Safeway, Save Mart, Save-on, Shopko, RiteAid, Target, Von's Food & Drug, Walgreens, and Wal-Mart.

To locate a participating pharmacy closest to your home or workplace, call the OptumRx Help Desk at (888) 354-0090 and request a zip code search. Or you can locate this information online by accessing OptumRx.com.

(b) *Benefits.* You may receive benefits under the Self-Funded PPO prescription drug program through a retail pharmacy, by mail order or by direct reimbursement.

(1) Retail Pharmacy. Participant coinsurance collected at Pharmacy:

Generic Drug	Lesser of 20% of retail price or $7/script
Brand Name Drug	20% of retail price

30-day maximum supply allowed with each prescription.

(2) Mail Order (Recommended for Maintenance Medications). Participant coinsurance paid by check or credit/debit card:

Generic Drug	Lesser of 20% of retail price or $17.50/script
Brand Name Drug	20% of retail price

90-day maximum supply allowed with each prescription with up to three refills if appropriate.

(3) Specialty Pharmacy. Participant co-insurance/copayment paid by check or credit/debit card

Generic Drug	Lesser of 20% of Specialty price or $150/script
Brand Name Drug	Lesser of 20% of Specialty price or $150/script

(c) *Covered Drugs.* Drugs covered under the prescription drug card program include federal legend drugs (drugs approved by the FDA requiring a written prescription), bee sting kits, Depo Provera, diabetic test strips, lancets, diaphragms, glucogan, immunosuppressants, insulin/syringes (must be on a written prescription), one glucose meter per year, acne/dermatological products (through age 40 with prior authorization), Viagra (limit 8 tablets/30 days) and vitamins (prescription only). If cost of compound medication exceeds $200 per prescription, prior authorization is required. Certain medications may be subject to quantity level limits and/or dosing limits.

(d) *Excluded Drugs.* Drugs not covered under the prescription drug card program include appetite suppressants/weight loss agent, blood and blood plasma*, cosmetic drugs, drugs and devices administered at the doctor's office, rest home or hospital, fertility drugs, growth hormones, immunization* and vaccinations*, injectables not self-administered or otherwise available through the specialty drug program described below*, medical supplies and appliances*, over-the-counter products (with the exception of proton pump inhibitors and non-sedating antihistamines with a written prescription, as described below) and over-the-counter vitamins and nutritional products. To the extent that any of the items in this subsection are considered preventive care and provided under subsection (e) below, they will not be excluded.

* Note: items with an asterisk are covered under the Self-Funded PPO.

(e) *Preventive Care.* The Plan pays 100% of the cost for several Preventive Care medications. You will not be charged a copayment for specific over-the-counter drugs, supplements and immunizations described below if you or your covered family member meets the age limits or other requirements. You should request a prescription from your physician, and in cases where coverage only applies to generics or over-the-counter medications, make sure to request a generic or over-the-counter prescription. Present your pharmacy ID card and your prescription to your pharmacy, and the pharmacy will process your prescription without a copay. The following is a partial list of Preventive Care prescriptions:

(1) Aspirin (325 mg. or less) for men and women beginning at age 45.

(2) Contraceptives:
  (A) over-the-counter female contraceptive products;
  (B) prescription contraceptive drugs; and
  (C) prescription contraceptive devices.

(3) Folic acid supplements and prenatal vitamins for women younger than 55.

(4) Immunization vaccines.

(5) Iron Supplements for children ages 6 months to 12 months.

(6) Oral fluoride supplements for children ages 6 months to 6 years.

(7) Shingles vaccine for adults age 50 and older.

A complete list of Preventive Care health services, including over-the-counter drugs, supplements, and immunizations can be found at HealthCare.gov/center/regulations/prevention.html.

(f) *Direct Member Reimbursements.* New members may submit claims for prescriptions not billed through OptumRx by filling out a Direct Member Reimbursement Claim Form (you can locate forms at OptumRx.com). Direct member reimbursements submitted within the first 60 days of eligibility under the Plan will be paid at amount claimed minus the copayment.

Direct member reimbursements submitted after the first 60 days of eligibility will be paid at the contracted rate minus the copayment. Please remember to always use your prescription drug card when obtaining your medications.

(g) *Coordination of Benefits.* If you have other prescription drug coverage through another group provider that is primary, the Plan, as secondary carrier, will coordinate benefits by reimbursing you for the primary plan's out-of-pocket copayment. This can be done at the retail pharmacy by using your prescription card for your primary carrier and then your Plan prescription coverage card as secondary carrier. If you do not have your SFEW prescription coverage card when the pharmacist fills your prescription, you may also seek reimbursement by submitting a Direct Member Reimbursement Form to OptumRx with your receipt showing the amount you paid and the amount your primary insurance paid.

(h) *Over-The-Counter (OTC) Program Options for Proton Pump Inhibitors (PPIs) and Non-Sedating Antihistamines (NSAs)*. The Plan will cover the full cost of prescription strength PPIs (OTC Prilosec, Omeprazole, Prevacid, and Zegerid) and NSAs (OTC Claritin, Alavert, Claritin D, Allegra, Allegra-D, Zyrtec, and Zyrtec-D) over-the-counter ("OTC") for no copayment, provided you have a prescription. In order to have the $0 copayment apply, you will need to present your prescription drug card, the OTC medication and your prescription from your doctor to the pharmacist. Your pharmacist can call your doctor for a prescription, but you must present your drug card to the pharmacy in order to have the $0 copayment apply. This program is optional.

(i) *Specialty Drug Program.* This program provides one-on-one service and active management of biopharmaceuticals (e.g. Infertility Agents, Hepatitis C), and a more cost effective solution for specialty medications. A "Member Care Specialist" is assigned to contact individuals who have been prescribed certain medications to make sure that they are taking them, as prescribed, and understand how to deal with any side effects that may occur. These medications are sent directly to the members' homes, and clinical pharmacists that are dedicated to the specialty pharmacy are available on a 24-hour basis to answer questions or concerns. Participant coinsurance, under this program, is 20%, up to a maximum of $150 per script. Prior authorization will be required on all specialty categories to the market.

(j) *Step Therapy and Dispense as Written (DAW) Medications*. The Self-Funded PPO prescription drug program includes a "step therapy" program for select drugs. Step therapy is an automated program that a pharmacist uses to review a patient's medication history, often resulting in an alternative (sometimes generic) medication to replace a more costly brand medication. The program requires a patient to try a clinically appropriate, lower cost medication first, or an equivalent unless a physician provides medical documentation that a patient has tried and failed an alternative (generic) medication in the recent past.

(1) Generic Incentive Program. The "generic incentive" program promotes the use of FDA-approved generic medications. The program concentrates on brand prescription medications that have equivalent (the same active ingredient) generics available and require a patient to try the equivalent generic first. If a covered individual chooses not to participate in the generic incentive program that individual will be required to pay the applicable copayment described above plus the total cost difference between the brand and the equivalent generic, unless clinical documentation from the prescribing physician indicates the reason the generic medication cannot be tolerated.

Note: These penalties will not apply to higher cost drugs that were initially prescribed before August 1, 2011.

Quantity Level Limits and dosing limits. Certain medications have quantity level limits and/or quantity duration management per day supply based on the FDA recommended dosing guidelines. These medications also include the classification such as Hepatitis C treatment, migraine medications, sleep aids, pain management medications, opioids and narcotics. These agents have a quantity per day supply as well as a duration management.

(2) Opioid Management Program. The Plan uses OptumRx to provide opioid management services. For home delivery, the program requires electronic prescriptions to fill controlled substances, and limits dispensation of opioid prescription to a maximum 30-day supply. If you need to dispose of excess supply of opioids, please contact OptumRx to obtain a drug disposal kit.

(3) Medical Exception and Clinical Appeals. An exception process is available for members that have experienced an adverse drug reaction (ADR) while using generic prescription medication under the care of a physician. The prescribing physician may request a medical or clinical exception on behalf of a member when providing clinical documentation including the generic name, adverse drug reaction experienced and the date of fill for an exception to be approved. Please have your physician provide a letter of medical necessity with this information. Contact numbers for the physician to contact the OptumRx Prior Authorization Department are as follows:

- (800) 527-0531 (Fax)
- (800) 711-4555 (Tel)

(3) Information: Telephone/Websites/ Mail Order Address. For your reference, you may also access the FDA's website for comprehensive information about generic drugs: http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/UnderstandingGenericDrugs/default.htm.

OptumRx Website:	OptumRx.com
OptumRx Help Desk:	(888) 354-0090
OptumRx Mail Order Help Desk:	(800) 797-9791
OptumRx Mail:	P.O. Box 509075 San Diego, CA 92150-9075

8.6 Limits on Covered Charges.

(a) *Deductible.* The deductible is $150 per Covered Individual up to a maximum of $300 per family for each calendar year. This is the out-of-pocket expense for which you are responsible. Charges that are not Covered Charges and charges you pay as a coinsurance may not be used to satisfy the deductible amount. The deductible amount is subtracted from your Covered Charges and the remaining amount is multiplied by the coinsurance percentage to determine your amount payable. If charges in the last three months of a calendar year are applied toward the deductible, these charges will also be applied toward the deductible for the next calendar year.

After the family deductible has been satisfied in a calendar year, no further deductible is required of that family unit for charges incurred in the remainder of that calendar year.

(b) *Coinsurance.* Except as provided otherwise in this section, after the deductible described in subsection (a) has been satisfied, Covered Charges will be paid at 80% of the contracted rate (100% for mental health and substance abuse charges) incurred in a calendar year performed by a Preferred Provider or at a Preferred Provider facility (*i.e.*, an "in-network" provider or facility), and at 60% of Reasonable and Customary charges if not performed by a Preferred Provider or at a Preferred Provider facility (*i.e.*, an "out-of-network" provider or facility), including for mental health and substance abuse charges. The 20% (or 40%) balance is your coinsurance and is an out-of-pocket expense for which you are responsible. Once you or your Dependent have accumulated the maximum out-of-pocket Covered Charges described in subsection (d), the Plan will pay the balance of Covered Charges incurred during the remainder of the calendar year at 100% for services performed in-network and at 80% for services performed out-of-network. Your Covered Charges are paid only to the extent provided in this section, so you should use in-network Physicians and Hospitals if you wish to minimize your out-of-pocket cost. Any out-of-network balances you are required to pay do not count toward your out-of-pocket annual maximum under subsection (d).

(c) *Maximum Annual Out-of-Pocket Limit.* A Covered Individual shall not be required to pay in-network Covered Charges exceeding $1,500 per calendar year. Once a Covered Individual has paid $1,500 of out-of-pocket in-network Covered Charges in a calendar year, the Plan will pay the balance of Covered Charges incurred during the remainder of the calendar year at 100% for in-network services at the PPO contract rate and at 80% the usual and customary or the reasonable and customary for out-of-network services. In no event will the out-of-pocket in-network Covered Charges exceed the maximum amount allowable under the ACA, which for 2023 is $18,200 per family.

(d) Special Rules for Out-of-Network Emergency Care. If you experience a medical condition with acute symptoms (including severe pain) such that you require emergency care to address a serious threat to your (or your unborn child's) health and/or the functioning of an organ or other part of your body, you may seek emergency care without prior authorization and without regard to whether the emergency care provider (e.g., a hospital) is in-network or out-of-network. The Plan will cover the charges of an out-of-network emergency care provider at least to the extent of what the Plan negotiated for the services with in-network providers (excluding any in-network co-payment or coinsurance imposed on the Participant or Dependent) in accordance with 45 C.F.R. Section 147.138(b) and the No Surprises Act.

(e) *Retirees.* In general, the provisions of this article apply similarly to covered Retirees, except that the Plan will offset Covered Charges for a Medicare-eligible Retiree or Dependent by the amount payable by Medicare or the amount that would be payable by Medicare if the Covered Individual had enrolled in Medicare Parts A and B. (See Section 4.5(b).) Payments made pursuant to Medicare are subject to the satisfaction of any deductibles and the application of any Plan benefit maximums or coinsurance.

(f) *Maximum Annual Plan Benefit.* The Plan imposes no annual maximum.

8.7 Early Medical Assessment and Case Management. The Plan has contracted with Blue Shield to provide the following Clinical Management Services which are not designed to interfere with the decisions between you and your medical provider.

(a) *Preadmission Certification.* All medical providers are requested to contact Blue Shield, prior to any non-emergency hospitalizations and out-patient procedures (including acute care admissions, and admission to any skilled nursing or long-term acute care facility) at (800) 541-6652 to verify that services are Medically Necessary and that planned treatment is at the appropriate level of care. This preadmission process also promotes early assessment of high-risk patients that would benefit from disease and high-risk case management administered by Blue Shield.

(b) *High-Risk Case Management.* This program offers you information and support through a local care manager who is a registered nurse. Your care manager acts as an advocate for you and your family by helping you:

- Identify treatment options available to you that may assist you in making important healthcare decisions
- Coordinate your care with your healthcare providers
- Research additional resources, such as support groups and financial assistance

(1) *Here's how it works:* A care manager from your area will visit you to understand your needs and to discuss ways he or she can help you. A team of specially trained nurses and doctors will review your treatment options and share the options with you. You can be certain that your medical history and information will be kept confidential. With your permission, the care manager will contact your doctor to offer assistance. Your local care manager will be your primary program contact. However, you and your doctor will always make the decisions about your treatment options. By working closely with your doctor and using the resources available in your community, this program can help you through a difficult time.

(c) *Disease Management.* This program is designed to help members manage their chronic conditions and improve their quality of life for asthma, diabetes, heart disease, coronary artery disease, and chronic obstructive pulmonary disease. This "whole person" approach includes monitoring from an entire team including a pharmacist, nutritionist/dietician and mental health counselor. Enrolled members receive interactive online support, as well as educational mailings and are invited to call as needed. Those at higher risk are contacted telephonically by a registered nurse and certain of those members may be provided with biometric monitoring. Participation in both the high risk case management and disease management programs will not affect your benefits. You decide whether to participate in these voluntary programs. There are no extra charges for this service, and you can leave the program at any time, for any reason.

(d) *Mental Health.* The clinical management of Mental Health services are managed through Magellan Health Services. Magellan performs medical management services including preauthorization, concurrent review, discharge planning, and aftercare monitoring. The Plan's mental health program through Magellan provides medical care management services for members by specialized clinicians who have access to readily available experts and clinical supports on a 24-hour/7 day a week basis. To access a care manager, call (877) 263-9952.

Detoxification (Hospital). With the exception of an emergency or urgent detoxification need, pre-authorization of detoxification services by Blue Shield is required. Such services are to be rendered in an acute care hospital.

(e) *Substance Abuse*. Beat It! Employee Assistance Programs provide Participants and Dependents confidential assistance with substance or alcohol issues. To access the national 24-hour/7 day a week client hotline please call (800) 828-3939. Except in the case of an emergency, pre-authorization by Beat It! is required for full coverage of in-patient substance abuse treatment. See Section 8.9 (32) for Covered Charges.

(f) *NurseHelp 24/7.* Registered nurses are available around-the-clock to provide health advice and education to Participants. These services, available at no cost to the Participant, may be accessed either online or by logging onto blueshieldca.com or call NurseHelp 24/7 at (877) 304-0504.

(g) *Teladoc*. California licensed board-certified doctors are available by phone or video 24 hours per day, 7 days per week for consultation on many non-emergency illnesses, including but not limited to allergies, bronchitis, cold and flu symptoms, nausea, rash, upset stomach, sinus infection, and sore throat. These services may be accessed by visiting blueshieldca.com/Teladoc, by downloading the app at teladoc.com/mobile, or by calling (800) 835-2362.

8.8 Life Referrals 24/7 Program. PPO benefits include the "Life Referrals 24/7" program, which is a free confidential referral service designed to help Covered Individuals and other members of the Participant's household resolve personal problems that may be interfering with work or home life. The program provides referrals to counselors and other experienced professionals to assist with personal, family, financial, legal and work-related issues including:

(1) Balancing work with personal life: managing stress, situational conflicts, and transitions

(2) Marriage and relationships: strengthening bonds and improving communication

(3) Mental health: managing anxiety, depression and personal crises, alcoholism, drug abuse and co-dependency

(4) Death and dying: coping with chronic and terminal illness, grief and loss

(5) Financial assistance: consulting with financial advisers on money matters

(6) Legal assistance: consultations and discounts on a variety of legal services

(7) Adult and elder support services: help with aging parents and family, including in-home and long-term care, transportation, and housing

(8) Child and parenting support services: meeting parenting challenges, day care, tutoring, pregnancy, adoption, and child development

(9) Family and relationship services: dealing with parent-child conflicts, single parent challenges and better communication

(10) Lifelong learning: information about schools, classes, and other opportunities for growth

(11) Chronic condition support services: information and support for members living with a chronic condition

To access the Life Referrals 24/7 program, call the program's hotline at (800) 985-2405 or log on to blueshieldca.com. This program is also available under the Blue Shield HMO.

8.9 Covered Charges. Benefits are payable only for Covered Charges. A Covered Charge is a fee or other expense for a charge that is the lesser of a Reasonable and Customary charge or contracted rate, is incurred by a Covered Individual, is Medically Necessary for a condition that is covered under the Plan, and is not excluded under Section 8.9. Covered Charges that satisfy these conditions may include:

(1) Acupuncturist. For up to a maximum of 30 visits per calendar year for charges of a licensed acupuncturist.

(2) Ambulance/Transportation. For transporting the patient to the most appropriate Hospital or skilled nursing facility where treatment is given and when Medically Necessary, and where transportation in any other vehicle could endanger your health. Emergency ambulance transportation in an airplane or helicopter to a hospital may be covered if such transport is (i) is needed immediately and rapidly and (ii) ground transportation cannot provide the necessary transportation with speed and immediacy. Some limited non-emergency ambulance transportation may be covered if you have a written order from your doctor stating that ambulance transportation is necessary due to your medical condition. The Plan will only cover ambulance services to the nearest appropriate medical facility equipped to provide the required treatment.

(3) Anesthesia. For anesthesia and its administration.

(4) Annual Physical. To the extent certain Preventive Care services are included in the annual physical, such services shall be covered without cost-sharing and without a monetary limit if provided by an in-network provider.

(5) Blood. For blood or blood plasma not replaced, including the storage of the patient's blood when approved or recommended by the attending Physician or surgeon.

(6) Cancer Treatment. For use of radium and radioactive isotopes and/or cancer chemotherapy treatment.

(7) Cataract Surgery. For contact lenses or eyeglasses and frames required immediately following and as a result of cataract surgery.

(8) Chiropractor. For up to a maximum of 30 visits per calendar year for charges by generally accepted chiropractic standards when treated by a licensed chiropractor.

(9) Colorectal Cancer Screening. The 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 cms.hhs.gov/colorectalcancerscreening. For adults over age 50, colorectal cancer screening is a Preventive Care service

(10) Drugs. For drugs and medicine obtainable only upon the written prescription of a Physician and dispensed by a licensed pharmacist, including insulin and diabetic supplies (administered through OptumRx's prescription drug card program - see Section 8.5).

(11) Early Screenings. For the following early screenings, based on Medicare guidelines:

Procedure	**Frequency for Normal Risk Participants**	**Frequency for High Risk Participants**
Pap Smears and Pelvic Exams	Once every 24 months	Once every 12 months
Prostate Cancer Screenings	Once every 12 months for men age 50 and older	
Mammogram Screenings	One baseline screening mammogram for women 35 to 39 years of age; once every 12 months for women 40 years and older	Diagnostic mammograms when a screening mammogram shows an abnormality

(12) Immunizations. Charges for immunizations (other than travel immunizations). Benefits are limited to immunizations that are recommended by the American Academy of Family Physicians or the patient's Physician. Certain immunizations are considered Preventive Care services and will be covered without cost-sharing if provided by an in-network provider.

(13) Injectable Drugs. For injectable drugs, including syringes and needles. (Some injectable drugs are covered through OptumRx's drug program. See Section 8.5.)

(14) Intensive Care or Coronary Care. For accommodations in an intensive care unit or coronary care unit which are in excess of the semiprivate rate, when required for the treatment of a critically ill or injured person.

(15) Laboratory Tests and X-Rays. Certain laboratory tests may be considered Preventive Care services.

(16) Skilled Nursing Facility (SNF). SNF Hospital Covered Charges are reimbursable after an in-patient Hospital confinement of at least 3 days, up to a maximum confinement is 100 days, reduced by the number of days of Hospital confinement. Successive Hospital confinements (including convalescent hospital confinements) will be considered a single confinement unless separated by a period of 30 days or the second confinement is due to a new accidental injury. Medicare eligibility guidelines for SNF coverage are applicable. This means you must submit a physician's certification that SNF care is necessary, you must be admitted to the SNF within 30 days following a minimum 3-day hospital stay, that you require daily skilled nursing or rehabilitation (as opposed to custodial care only) and the care is only available in a SNF on an in-patient basis. Only Medicare-certified SNF providers are covered providers for Medicare-eligible Participants.

A Skilled Nursing Facility is a nursing facility that meets federal and state licensing standards, with the staff and equipment to give skilled nursing care and, in most

cases, skilled rehabilitative services and other related health services. Skilled nursing care is care given or supervised by Registered Nurses who provide direct care, manage, observe and evaluate a patient's care; and teach the patient and his or her family caregiver.

(17) Maternity Charges. For maternity-related services for a Participant, Spouse, or Domestic Partner but excluding maternity charges incurred by a Dependent other than for complications of pregnancy. Charges due to elective abortion are not Covered Charges except where the life or health of the mother would be endangered if the fetus were carried to term, or those charges that directly result from complications of an abortion. Expenses for "well-baby" care are not covered, with the exception of a "well baby Physician's Hospital visits." For this purpose, "complications of pregnancy" means (i) conditions that require Hospital confinements (when the pregnancy is not terminated), for which diagnoses are distinct from pregnancy but are adversely affected by pregnancy, or which are caused by pregnancy, and (ii) non-elective Cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

(A) *Extended Maternity Coverage*. A Participant, Spouse, or Domestic Partner who is pregnant on the date of termination of her coverage will be entitled to the applicable benefits for Covered Charges due to her pregnancy even though she may not be totally disabled on the date of termination provided (i) the pregnancy commenced while such individual was eligible for coverage under the Plan and (ii) such individual is not eligible for coverage under any other group plan providing similar benefits for the pregnancy.

(B) *Coverage of Post-Delivery Hospital Stay*. Charges for maternity-related care will be provided on the same basis as any other Illness, except that charges for in-patient Hospital treatment for childbirth delivery will be provided for the mother's newborn child for 48 hours following normal vaginal delivery and 96 hours following delivery by Caesarean section. The mother and newborn child may be discharged earlier than the above indicated time periods if (i) the treating Physician or Other Accredited Provider, in consultation with the mother, makes the decision to discharge the mother and child for an earlier time period, and (ii) a post discharge follow-up visit for the mother and newborn child is provided within 48-hours of discharge if prescribed by the treating Physician and the visit is provided by an Other Accredited Provider whose scope of practice includes postpartum care and newborn care, and may include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments.

(18) Mental Health. Charges for inpatient hospital, outpatient facility, and professional services, including psychological testing, and behavioral health treatment, for mental health conditions. (See also Section 8.7(d).) In-network treatment is covered at 100% of the contracted PPO rate and out-of-network treatment is covered at 60% of Reasonable and Customary Charges.

(19) Nursing. Made by a registered nurse, a licensed vocational nurse or licensed practical nurse, for private duty non-custodial nursing service.

(20) Osteoporosis. For the treatment of osteoporosis, including all FDA-approved technologies, including bone mass measurement technologies as deemed medically appropriate by a Physician.

(21) Outpatient Facilities. For services rendered for out-patient surgery if the patient undergoes a surgical procedure which would normally be performed in a Hospital but which can be performed in an ambulatory out-patient surgical facility or a Physician's office. The patient has the right to choose between having the procedure performed in the ambulatory out-patient surgical facility, the Physician's office, or in the Hospital.

(22) Oxygen. For oxygen and purchase or rental of equipment for its administration. The benefit limit for rental will not exceed the purchase cost.

(23) Pre-admission and X-Rays. Made by a Hospital for pre-admission testing for diagnostic tests performed and x-rays taken, in the Hospital's out-patient department in connection with a scheduled Hospital admission for treatment of Injury or Illness covered by the Plan, provided tests are (i) made within 7 days prior to admission, (ii) ordered by the same Physician who ordered the admission, and (iii) the same tests that would have been ordered during the hospital confinement. If the scheduled admission is canceled or delayed, the benefit will still be paid if (i) the tests reveal a condition that requires treatment prior to the admission, (ii) a medical condition develops that delays the admission, (iii) a hospital bed is not available on the scheduled date of admission or (iv) the tests indicate that the admission is not necessary.

(24) Preventive Care Items and Services. The Plan pays 100% of all Preventive Care "in-network" Covered Charges. A complete list of the Preventive Care health services can be found at www.HealthCare.gov/center/regulations/prevention.html.

If a Preventive Care item or service is billed separately from an office visit, the office visit may not be treated as a Preventive Care Covered Charge. If a Preventive Care item or service and office visit are not billed separately and the primary purpose of the office visit is the delivery of the Preventive Care item or service, the office visit will be treated as a Preventive Care Covered Charge; but if the delivery of the Preventive Care item or service is not the primary purpose of the office visit, the office visit may not be treated as a Preventive Care Covered Charge. A Preventive Care item or service may not be treated as a Preventive Care Covered Charge until the first day of the Plan year beginning on or after the date on which the service or treatment is designated as a Preventive Care item or service.

(A) *Preventive Care Items and Services for Children*

(i) A single Physician's visit, including immunizations and laboratory services in connection with such visit, at approximately the following ages:

(a) birth;

(b) 2, 4, 6, 9, 12, 15 and 18 months of age; and

(c) 2, 3, 4, 5, 6, 8, 10, 12, 14 and 16 years of age;

(ii) Alcohol and drug use assessments for adolescents;

(iii) Autism screening for children at 18 and 24 months;

(iv) Behavioral assessments for children of all ages;

(v) Blood pressure screening;

(vi) Cervical dysplasia screening for sexually active females;

(vii) Congenital hypothyroidism screening for newborns;

(viii) Depression screening for adolescents;

(ix) Developmental screening for children over age 3, and surveillance throughout childhood;

(x) Dyslipidemia screening for children at higher risk of lipid disorders;

(xi) Flouride chemoprevention supplements for children without fluoride water source;

(xii) Gonorrhea preventive medical for the eyes of all newborns;

(xiii) Hearing screening for all newborns;

(xiv) Height, weight, and body mass index measurements;

(xv) Hematocrit or hemoglobin screening;

(xvi) Hemoglobinpathies or sickle cell screening for newborns;

(xvii) HIV screening for adolescents at higher risk;

(xviii) Immunization vaccines from birth to age 18;

(xix) Iron supplements for children 6 to 12 months at risk of anemia;

(xx) laboratory services in connection with routine physical examinations;

(xxi) Lead screening for children at risk of exposure;

(xxii) Medical history;

(xxiii) Obesity screening and counseling;

(xxiv) Oral health risk assessment for young children ages 0 to 10 years;

(xxv) Plenylketonuria (PKU) screening for newborns;

(xxvi) Physician’s services for routine physical examinations;

(xxvii) Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk;

(xxviii) Tuberculin testing for children at higher risk of tuberculosis; and

(xxix) Vision screening.

(B) *Preventive Care Items and Services for Adults*

(i) Abdominal aortic aneurysm one-time screening for men of specified age who have ever smoked;

(ii) Alcohol misuse screening and counseling;

(iii) Aspirin for adults of certain ages;

(iv) Blood pressure screening;

(v) Cholesterol screening for adults of certain ages or at higher risk;

(vi) Depression screening;

(vii) Diet counseling for adults at higher risk for chronic disease;

(viii) Type 2 diabetes screening for adults with high blood pressure;

(ix) HIV screening for adults at higher risk;

(x) Immunization vaccines;

(xi) Obesity screening and counseling;

(xii) Sexually transmitted infection (STI) prevention counseling for adults at higher risk;

(xiii) Tobacco use screening for all adults and cessation interventions for tobacco users; and

(xiv) Syphilis screening for adults at higher risk.

(C) *Preventive Care Items and Services for Women, including Pregnant Women*

(i) Anemia screening on a routine basis for pregnant women;

(ii) Bacteriuria urinary tract or other infection screening for pregnant women;

(iii) BRCA counseling about genetic testing for women at higher risk;

(iv) Breast cancer mammography screening every 1 to 2 years for women over 40;

(v) Breastfeeding comprehensive support and counseling and access to breastfeeding supplies for pregnant and nursing women;

(vi) Cervical cancer screening for sexually active women;

(vii) Chlamydia infection screening for younger women and women at higher risk;

(viii) Contraception (FDA-approved methods, sterilization procedures, and patient education and counseling);

(ix) Domestic and interpersonal violence screening and counseling;

(x) Folic acid supplements for women who may become pregnant;

(xi) Gestational diabetes screening for women 24 to 28 weeks pregnant and those at higher risk;

(xii) Gonorrhea screening for all women at higher risk;

(xiii) Hepatitis B screening for pregnant women at their first prenatal visit;

(xiv) HIV screening and counseling for sexually active women;

(xv) HPV DNA tests every 3 years for women with normal cytology results who are 30 or older;

(xvi) Osteoporosis screening for women over 60 depending on risk factors;

(xvii) Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;

(xviii) Tobacco use screening and interventions, and expanded counseling for pregnant tobacco users;

(xix) Syphilis screening for all pregnant women or women at higher risk; and

(xx) Well-woman visits to obtain recommended preventive services.

(25) Professional Medical Services. For professional medical services of a Physician or Other Accredited Provider.

(26) Prosthetic Services and Appliances. For initial and subsequent post-mastectomy prosthetic devices and prosthetic appliances such as artificial limbs or eyes.

(27) Rental of Durable Medical Equipment. For the rental (not to exceed the purchase price) of durable medical equipment such as a wheelchair and hospital-type bed. Durable equipment means equipment or FDA-approved medical devices that are medically necessary to aid in recovery, mobility and/or the support of life. Such durable medical equipment must (i) be prescribed by the attending Physician, (ii) be designed for prolonged use and (iii) not be primarily used for non-medical purposes.

(28) Transplant Benefits. All transplant procedures must be preauthorized and no out-of-network expenses will be payable.

(A) *Cornea, Kidney or Skin.* Benefits are provided only for human organ transplant services rendered at contracting facilities and by contracting providers to the extent they are (i) provided in connection with the transplant of a cornea, kidney, or skin, when the recipient of such transplant is a Participant and (ii) services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank.

(B) *Special Procedures.* Benefits are provided only for transplant services rendered at special transplant facilities, when the recipient of such transplant are Participants or Dependents, for the following:

(i) Human heart transplants;

(ii) Human lung transplants;

(iii) Human heart and lung transplants in combination;

(iv) Human liver transplants;

(v) Human kidney and pancreas transplants in combination;

(vi) Human bone marrow transplants;

(vii) Pediatric human small bowel transplants;

(viii) Pediatric and adult human small bowel and liver transplants in combination; and

(ix) Services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank.

The following schedule summarizes amounts paid by the Plan for transplant expenses related to organ donor costs and travel.

Benefit Description	**Plan Pays**	**Additional Limitation and Explanations**
Organ donor costs per transplant	$100,000	Travel, lodging and meals allowance is for the transplant recipient and his or her immediate family travel companion (both parents, if patient under age 19). Transplants performed outside the Shared Advantage Transplant Program will not be covered, including any donor expenses or travel, lodging and meals related to the transplant.
Travel, lodging and meals allowance per transplant	$10,000	

(29) Speaking Assistance. For prosthetic devices to restore a method of speaking for the patient incident to a laryngectomy, including the initial and subsequent prosthetic devices or installation accessories, as prescribed by the treating Physician, but will not include electronic voice producing machines.

(30) Stand-by Surgeon. For services by a stand-by surgeon when necessary due to the risk of the surgical procedure.

(31) Sterilization. Charges for sterilization of the reproductive system, including vasectomy and tubal ligation.

(32) Substance Abuse. Charges for the treatment of substance abuse conditions, including residential rehabilitation treatment centers. In-network treatment through Beat It! is covered at 100% of the contracted PPO rate and out-of-network treatment is covered at 60% of Reasonable and Customary Charges. Charges for medical detoxification, including hospitalization, are covered as medical, rather than substance abuse treatment benefits.

Beat It! Employee Assistance Programs provide coordination and referral services for substance abuse treatments, including residential rehabilitation treatment centers.

(33) Support. For initial truss, brace, or support, cast splints, and crutches.

(34) Surgical. For surgical procedures, whether or not stored blood is used.

(35) Tempo-mandibular Joint Dysfunction. For the treatment of Tempo-Mandibular Joint Dysfunction syndrome ("TMJ"), or any other treatment of the face, neck, or head is covered on the basis as any other treatment of the skeletal system. Charges for intra-oral prosthetic devices are excluded.

(36) Therapist. For charges of a licensed or registered physical therapist or occupational therapist. Contact the Plan Office for an evaluation before starting treatment since the number of visits may be limited depending upon the nature of the Illness or Injury. Claims will be referred to the Plan's medical review department or an independent medical reviewer to determine Medical Necessity and appropriate frequency of treatment based on information provided by the caregiver in most instances.

(37) Treatment. By a Hospital, for out-patient and in-patient treatment. Covered Charges for in-patient treatment are limited to the Hospital's regular rate for semi-private accommodations. If the Hospital does not have semi-private accommodations, the Plan will pay 75% of the minimum daily charges for room and board.

8.10 Exclusions. The following charges are excluded, are not Covered Charges, and will not be paid by the Plan:

(1) Excess of Reasonable and Customary. Any portion of a charge that is in excess of the Reasonable and Customary charge for the treatment.

(2) Not Medically Necessary. Any charge for treatment that the Plan determines is not Medically Necessary.

(3) Experimental or Not Generally Accepted Treatment. Subject to the exceptions described in the definition of "Experimental or Not Generally Accepted," charges incurred for a treatment that is Experimental or not Generally Accepted.

(4) No Legal Obligation to Pay. Charges for which a member is not legally obligated to pay, or treatment which he or she obtains, or is entitled to obtain, under any plan or program without charge, other than Medicaid or Medi-Cal. This will include charges for treatment which is provided or paid for by the federal government at a Veteran's Administration facility for (i) an Injury or Illness related to the patient's military service or (ii) the member or his or her Dependents, if retired from the armed services.

(5) Non-Covered Individual. Charges incurred by someone other than a Covered Individual, even if living in the same household.

(6) Third Party Responsible. Charges incurred for which a third party is responsible; provided, however, that benefits may be advanced by the Plan pending determination by way of court or administrative determination of third-party liability or by way of settlement, whether or not the third party is responsible for payment of medical and Hospital costs. (See also Section 8.13.)

(7) Act of War, Riot or Civil Disorder. Charges incurred as a result of an act of war (whether declared or not) and any related act, and charges incurred as the result of participation in a riot or civil disorder.

(8) Alternative Reproduction Birth Methods. Charges incurred in connection with (i) artificial insemination, (ii) in vitro fertilization or (iii) in-vivo fertilization.

(9) Certain Eye Surgery. Charges incurred for surgery to the eye to correct a refractive error (such as radial keratotomy) and charges incurred for the purchase or fitting of eyeglasses or contact lens, but not including charges incurred for a contact lens or eyeglasses and frames required immediately following, and, as a result of, cataract surgery.

(10) Cosmetic Charges. Charges incurred in connection with treatment that is cosmetic; other than (i) reconstructive surgery to restore tissue damaged by Injury or Illness (including surgery on one or both breasts to re-establish symmetry following a mastectomy) or (ii) treatment of a Child from birth to correct a congenital disease or anomaly, including an oral defect.

(11) Custodial Care. Non-medical care that helps individuals with activities of daily living, preparation of special diets and self-administration of medication not requiring constant attention of medical personnel.

(12) Elective Abortion. Charges incurred for an elective abortion, except where the life or health of the mother is in danger if the procedure is not performed.

(13) Hearing Aids. Charges for hearing aids.

(14) Immunizations for Traveling Abroad. Travel immunizations are not covered.

(15) Personal Comfort Items. Charges for personal comfort items used for an individual's personal comfort, such as air purifiers, humidifiers, whirlpools, Jacuzzi or hot tub devices, exercise equipment, reclining chairs, bed boards, or other equipment not primarily medical in nature.

(16) Transportation. Charges for transportation, except professional ambulance services.

(17) Vitamins, Dietary Supplements, Weight-Control, Beauty Aids. Charges for multiple and non-therapeutic vitamins, dietary supplements, weight-control items, and health and beauty aids.

(18) Work-Related. Charges incurred as a result of (i) an Injury which arises out of or in the course of any employment with any other employer or (ii) an Illness for which the member or Dependent (a) is entitled to benefits under any workers' compensation law or occupational disease law or (b) receives any settlement from a workers' compensation or occupational disease carrier. (See also Section 8.13.)

(19) Treatment for ESRD Beyond 30 Months. The Plan will be the primary payer for treatment during any waiting period for Medicare benefits due to ESRD. After the Medicare waiting period, at which time you are entitled to Medicare benefits, the Plan will be the secondary payer. If you are eligible for Medicare due to ESRD but do not enroll in Medicare, the Plan will not cover the portion of your expense that Medicare would have paid, regardless of where you receive treatment.

8.11 Federal Mandates.

(a) *Newborn's and Mother's Health Protection Act*. The Self-Funded PPO generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a normal delivery, or less than 96 hours following a Cesarean section. Federal law does not, however, prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and her newborn earlier than the 48 hours, or 96 hours as applicable. In any event, the PPO may not require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(b) *Reconstructive Surgery After Mastectomy*. Under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), when the PPO provides medical and surgical benefits in connection with a mastectomy, the PPO must provide coverage in a manner determined in consultation with the attending Physician and the patient for (i) reconstruction of the breast on which the mastectomy was performed, (ii) surgery and reconstruction on the other breast to produce a symmetrical appearance and (iii) prostheses and physical complications of all stages of mastectomy, including lymphedemas. This coverage is subject to the PPO's annual deductibles and coinsurance provisions.

(c) *Other Federal Mandates*. In addition to compliance with other federal mandates discussed in this document, and to the extent applicable, the Self-Funded PPO will provide coverage and benefits in accordance with the requirements of the ACA, the Genetic Information Nondiscrimination Act of 2008 ("GINA," the provisions of which are explained in a poster titled "Equal Employment Opportunity is the Law" that is posted in your work area), the Mental Health Parity Act ("MHPA"), the Mental Health Parity and Addiction Equity Act ("MHPAEA"), and any other applicable federal law. Both HMOs will similarly comply with these and other federal mandates, and state law requirements, as set forth in the HMO contracts and as required by federal and state law.

8.12 Coordination of Benefits.

(a) *General Rules.* A Covered Individual may be covered by another group health plan or prescription drug card program in addition to this Plan, potentially resulting in both plans paying on the same claim. This section contains rules for the coordination of benefits. If a Covered Individual is covered under another group plan, the total amount to be paid from all plans will not exceed 100% of the amount of Covered Charges. This section does not apply to non-group (*i.e.*, individual) insurance coverage under which a Covered Individual may be covered. The Plan may obtain or release any information necessary to implement this subsection. You must declare your coverage under other group plans. The Plan can pay to another paying organization amounts warranted to satisfy the intent of this section and, to the extent of such payment, be discharged from liability for that claim. The Plan can also recover amounts that are overpaid under this section from you from any insurer or other organization. Information necessary to the administration of this provision will be required of you at the time a claim is submitted. Payment of the claim may be delayed if the required information is not provided.

(b) *Which Plan Pays First When You Are Covered Under More Than One Group Plan*

(1) If the other plan has a coordination of benefit provision, the plan that provides health care coverage (i.e., medical, hospital, prescription drug, vision and/or

dental) to you as an employee, former employee, or retiree (and not as a dependent) pays first.

(2) If you are covered as an employee or retiree under both health plans, the plan that has provided health care coverage to you longer is the primary payer.

(3) If you are covered as a current or active employee under one plan and a former employee under the other plan, the plan that covers you as an active employee will be the primary payer.

(4) If the other plan has no coordination of benefits provision, that plan is the primary payer.

(5) If a Child is covered under another plan, the plan of the parent whose birthday occurs earlier in the year is the primary payer. However, if the parents are divorced or are separated, the plan of the custodial parent is the primary payer. If joint custody applies, the plan of the parent whose birthday occurs earlier in the year is the primary payer. If the parent with custody remarries, the order of payment is as follows:

(A) natural parent with whom Child resides;
(B) stepparent with whom Child resides; then
(C) natural parent not having custody of the Child.

This order of payment can change if the child support order directs one of the parents to be financially responsible for the medical, dental or other health care expenses of the Child.

(c) *Which Plan Pays First When You Are Medicare Eligible*

(1) If you are covered as an Active Employee who has attained age 65 and are eligible for Medicare, coverage under the Plan is generally the primary payer. When the Plan is the primary payer, the Plan will pay first and Medicare second. You or your Dependent may, however, elect Medicare as primary. If Medicare is elected as the primary payer, your or your Dependent's coverage under the Plan will cease.

(2) If you are a Medicare eligible Retiree or former employee who has attained age 65, Medicare will be primary and the Plan will be secondary. See Section 8.6(e) for information on how the Plan adjudicates claims for Medicare eligible Retirees and Dependents.

(3) If you are a Medicare eligible Retiree or former employee who has attained age 65 and are covered in another plan as an employee, the plan that covers you as an employee will be primary. The order of payment is as follows:

(A) The Plan in which you are enrolled as an employee
(B) Medicare
(C) The SFEW (Retiree) Plan

(4) If you are a Medicare eligible Retiree or former employee who has attained age 65 and are covered in another plan as a dependent of an active employee, the plan that covers you as a dependent of an active employee will be primary. The order of payment is as follows:

(A) The Plan in which you are enrolled as an employee

(B) Medicare
(C) The SFEW (Retiree) Plan

If you or your Dependent are entitled to Medicare benefits before age 65 due to total disability or ESRD, the Plan will be the primary payer during any waiting period for Medicare benefits due to total disability or ESRD. After the Medicare waiting period, and you or your Dependent are entitled to Medicare benefits, the Plan will be the secondary payer; provided, however, that the Plan will be the primary payer if you are receiving Active Coverage and you or your Dependent are entitled to Medicare benefits due to total disability for other than ESRD.

8.13 Subrogation and Reimbursement.

(a) *Participant Must Agree to Subrogation and Reimbursement.* As a condition to the receipt of benefits under this article, a Covered Individual agrees:

(1) to reimburse the Plan to the extent any benefit payments are recovered from the proceeds of any judgment or settlement, payment or otherwise, on account of any illness, injury, or condition for which an employer, other third party (or their respective insurers), or your own personal, home, or automobile insurer may be liable, regardless of whether such recovery is less than the actual loss suffered by the person, and irrespective of whether responsibility is accepted or denied by an employer or third party;

(2) to waive any argument or contention that any action by the Plan in state court is pre-empted by federal law; and

(3) to assign to the Plan the Covered Individual's right of action against the employer, other third party (or their respective insurers), or your own personal, home, or automobile insurer to the extent benefits have been paid or may be paid in the future.

In addition, any Covered Individual must, as a condition to eligibility and the receipt of Plan benefits;

(4) notify the Plan Office within thirty (30) days of making a claim against an employer, other third party (or their respective insurers), or your own personal, home, or automobile insurer relating to an incident leading to damages, benefits or other compensation, of the fact and nature of such claim;

(5) furnish any information or assistance and execute any documents that the Plan may require; and

(6) take no action that may prejudice or interfere with such rights.

(b) *Subrogation & Reimbursement.* Whether or not the preceding requirements are satisfied, the Board:

(1) is automatically assigned a Covered Individual's right of action against an employer, other third party (or their respective insurers), or your own personal, home, or automobile insurer to recover benefits that have been paid or may be paid in the future;

(2) has the right to intervene at any time in any action brought against an employer, other third party (or their respective insurers), or your own personal, home, or automobile insurer to recover all benefits that have been paid or may be paid in the future;

(3) shall be reimbursed fully from the proceeds of any judgment, settlement, or other resolution of any action or proceeding to recover benefits that have been paid or may be paid in the future, regardless of whether the total amount of such recovery is less than the actual loss suffered by the person;

(4) shall be reimbursed 100% of the charges it paid in a lump sum at the time payment is received by a Covered Individual, his or her dependents, or his or her representative; and

(5) has an automatic first lien upon any recovery to the extent of benefits that have been paid or in the future may be paid.

In all instances set forth above in this subsection, the Board shall have such rights regardless of whether the total amount of the recovery is less than the actual loss suffered by the Covered Individual. The Board shall also be fully reimbursed for any charges paid in error, whether the error was that of the Plan, Participant, or Dependent.

(c) *Recovery by the Plan.* Should any Covered Individual fail to comply with any of the foregoing requirements, the Board may suspend that Covered Individual's ongoing eligibility for benefits and deny pending or future claims until such time that he or she is in compliance with such requirements. Should any Covered Individual enter into any settlement of any claim pursuant to state workers' compensation law or personal injury law (whether or not a lawsuit is filed) that does not include complete and final resolution of the Plan's lien, claim for reimbursement and/or subrogation claim immediately upon effectuation of such settlement, the Plan may suspend the Covered Individual's ongoing eligibility for benefits and deny pending or future claims until the Plan has recouped an amount equal to the value of such claim. Such recoupment may be accomplished via processing of medical benefit claims without payment of the amounts normally payable under the Plan. The Plan expressly rejects the application of legal theories such as the "collateral source," "make-whole" and "common fund" doctrines to the extent that they may prevent or limit the Plan's recovery from any payment that a Covered Individual receives from a third party (or its insurer). The Plan's reimbursement will not be reduced to pay any portion of the attorneys' fees and costs associated with the Covered Individual's legal recovery. This section applies to any no-fault insurance recoveries and all proceedings and actions, including but not limited to proceedings under any state workers' compensation acts, and any actions for negligence, medical malpractice, products liability, and other torts or wrongful acts.

(d) *Subrogation and Reimbursement for HMO Benefits.* Rules similar to those set forth above in this section shall apply to individuals covered under one of the HMOs to the extent provided in the applicable HMO contract.

IX. HMO OPTIONS

9.1 General Rules. As an alternative to the Self-Funded PPO, a Participant may elect coverage under one of following two HMOs offered under the Plan:

Blue Shield of California	Kaiser Foundation Health Plan, Inc.
Headquarters	1950 Franklin Street
601 12th Street	Oakland, CA 94612
Oakland, CA 94607	(800) 464-4000
Tel: (800) 642-6155	(800) 777-1238 (Senior Advantage)

The HMOs consist of networks of health care providers that have contracted with an organization (specifically, either Kaiser Foundation Health Plan, Inc. or Blue Shield of California) to provide medical services to Participants for a fixed payment. Both HMOs have separate written informational material that explain the services and benefits provided, as well as each HMO's limitations and exclusions. The HMO you select will provide you with complete written disclosures after you enroll, including an identification card. The medical facilities you must use are listed in the HMO packet you receive. Importantly, you must use the Physicians and Hospitals associated with the HMO you select. A Covered Individual who is covered under an HMO is ineligible for the benefits described in Article VIII.

Substance abuse related conditions. The only exception in which a Covered Individual under an HMO may use benefits described in Article VIII are for substance or alcohol abuse issues provided through Beat It! Employee Assistance Programs. Pre-authorization by Beat It! is required for full coverage of non-emergency in-patient substance abuse treatment. To access the confidential national 24-hour/7 day a week client hotline please call (800) 828-3939. See Section 8.9(32) for Covered Charges.

9.2 Enrollees Must Live in Service Area. To enroll in an HMO, the Participant must live or work within the HMO's service area. For the Kaiser HMO, your home or principal place of work zip code must be included within the Kaiser HMO's zip code. Accordingly, an HMO may not be available to all Participants because an HMO's service area may not include the area in which the Participant lives or works.

9.3 Incorporation of HMO Contract Into Plan. Any contract between the Plan and an HMO, to provide health care coverage to Participants and that has been duly approved and executed by the Board, is hereby incorporated into the Plan. Any such contract shall govern the determination of benefits payable to a Covered Individual who has elected enrollment in the HMO.

X. HEALTH REIMBURSEMENT ARRANGEMENT (HRA) ACCOUNTS

10.1 General Rules and Eligibility. All Local 6 members eligible for major medical coverage under the Plan are eligible to have contributions made to a Health Reimbursement Arrangement ("HRA"). The HRA allows you, as an eligible Participant, to maintain an employer-funded account alongside major medical coverage. Beginning with hours worked in June 2018, your Employer will contribute in accordance with its Contribution Agreement to an account established on your behalf that you may use to pay for qualified out-of-pocket medical expenses.

10.2 Qualified Expenses. Eligible members may use their HRA account balances to pay for qualified out-of-pocket health care expenses incurred by the participant and his or her spouse and dependents. Unless your Domestic Partner can be treated by the Plan as your spouse or dependent under the Internal Revenue Code, the HRA cannot reimburse his or her medical care

expenses on a tax-favored basis. Qualified medical expenses are described in detail in IRS publication 502. (See https://www.irs.gov/pub/irs-pdf/p502.pdf.)

Expansion of Qualified Medical Expenses. Effective January 1, 2020, over-the-counter products and medications are reimbursable without a prescription. Menstrual care products defined as tampons, pads, liners, cups, sponges or other similar products, are also reimbursable.

10.3 Submitting Claims. You may request reimbursement by filing a paper claim form for any out-of-pocket health care expenses you incur after the date you become eligible for the Plan coverage. After 2 consecutive months of coverage under the Plan, each member will receive a debit card ("**Health Debit Card**") linked to their HRA account that can also be used to pay out-of-pocket health care expenses. **Either payment method requires that you retain documentation of the medical expenses you incur**. **If you use a claim form, you must submit proper documentation along with the form. If you use the Health Debit Card, you may be asked for copies of this documentation afterward.** The card will remain active as long as you remain covered under the Plan and provide proper documentation for expenses paid with the card if requested by the HRA administrator.

10.4 Statements. HRA account statements will be mailed to you on a quarterly basis, though you may track your contribution credits and reimbursement charges at any time via the website at my.wexhealthcard.com. Unused HRA account balances reduced by an administrative fee accumulate and carry over from one year to the next. In addition, accounts can still be used after your employment terminates, before or after retirement. Statements for HRA accounts that have no activity for 12 months or more will be distributed on an annual basis.

10.5 Unused Account Balances and Forfeiture. Unused account balances may be used at any time, including following termination (loss of coverage under the Plan) or retirement as an Active Employee, up until your death. Upon your death, the balance in your HRA account may be used to reimburse your surviving spouse and any Child of yours until age 26 who was your Dependent upon your death.

XI. SUPPLEMENTAL BENEFITS

In addition to the medical benefits described in Articles VIII and IX, the Plan provides dental, vision, long-term disability, supplemental parental leave, emergency leave, pregnancy leave, and death benefits.

11.1 Dental Benefits.

(a) *General Rules.* Dental benefits are paid directly from the Trust (*i.e.*, they are not insured). The dental program is administered, however, by Delta Dental and uses Delta Dental's provider network. Employees and Early Retirees are covered under the Delta Dental Premier Plan (group ID numbers 04874-01005 and 04874-01015). Retirees are covered under the Delta Dental Preferred Option, or "DPO" (group ID numbers 4874-0015 and 4874-0016). Dependents are covered under the same plan as the Participant. To obtain dental services, a Covered Individual should make an appointment with any dentist listed on the Delta Dental provider list. All Delta Dental dentists will have Delta Dental treatment forms in their offices and should complete and submit the forms to Delta Dental for reimbursement. That Delta Dental provider list containing a complete list of Delta Dental dentists may be obtained by calling Delta's service department at (888) 335-8227 or it can be found at www.deltadentalins.com.

(b) *Summary of Benefits.* If you have specific questions regarding benefit structure, limitations, or exclusions, refer to the detailed discussions below, consult the Summary of Benefits provided by Delta, or contact Delta's service department. The following is a summary of the benefits available under the dental program.

Dental Services	**Percent of Delta Dental Fee Schedule Paid by Plan (Active Employees and Early Retirees)**	**Delta Preferred Option (DPO) Retiree Rates**	
		In-Network	**Out-of-Network**
Diagnostic & preventive (oral exams, cleaning) (twice per year), full x-rays (once per five years)	100%	100%	80%
Basic services (oral surgery, restorative treatment, root canals, gum treatment, ondontics, periodontics)	80%		
Orthodontic benefits			
Crowns, jackets & other cast restorations	80%	80%	60%
Prosthodontics (bridges, partial denture, full dental)	80%	80%	60%
Annual maximum	$4,000	$4,000	$4,000
Maximum orthodontics	$6,000	$1,500	$1,500

(c) *Your Benefits.* Your dental plan covers several categories of benefits, when the services are provided by a licensed dentist, and when they are necessary and customary under the generally accepted standards of dental practice.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, your Delta Dental dentist may charge you his or her Reasonable and Customary rate for those services. Prior to providing you dental services that are not a covered benefit, your dentist should provide you with a treatment plan that includes each anticipated service to be provided and the estimated cost of each service (see Predeterminations in subsection (n) below). If you would like more information about dental coverage options, you may call our Customer Service department at (888) 335-8227. To understand your coverage fully, you may wish to review carefully the information provided here. The Plan will provide payment for these services at the percentage indicated up to a maximum of $4,000 for each Covered Individual in each calendar year. Payment for Orthodontic Benefits for

an Active Enrollee is limited to a lifetime maximum of $6,000. Payment for Orthodontic Benefits for a Retiree is limited to a lifetime maximum of $4,000.

(1) Diagnostic and Preventive Benefits

(A) *Percent Covered*
100% if provided by Delta Dental dentists;
80% if provided by other dentists

(B) *Benefits Covered*

Diagnostic - oral examinations (including initial examinations, periodic examinations and emergency examinations); x-rays; diagnostic casts, examination of biopsied tissue; palliative (emergency) treatment of dental pain; specialist consultation

Preventive - prophylaxis (cleaning); fluoride treatment; space maintainers

(2) Basic Benefits

(A) *Percent Covered*
80% if provided by Delta Dental Dentists;
80% if provided by other dentists

(B) *Benefits Covered*

Oral surgery - extractions and certain other surgical procedures, including pre- and post-operative care

Restorative - amalgam, silicate or composite (resin) restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)

Endodontic - treatment of the tooth pulp

Periodontic - treatment of gums and bones that support the teeth

Sealants - topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay

Adjunctive General Services - general anesthesia; I.V. sedation; office visit for observation; office visit after regularly scheduled hours; therapeutic drug injection; treatment of postsurgical complications (unusual circumstances); limited occlusal adjustment

(3) Crowns, Inlays, Onlays and Cast Restoration Benefits

(A) *Percent Covered*
80% if provided by Delta Dental Dentists;
60% if provided by other dentists

(B) *Benefits Covered*
Crowns, inlays, onlays and cast restorations are Benefits only if they are provided to treat cavities which cannot be restored with amalgam, silicate or direct composite (resin) restorations.

(4) Prosthodontic Benefits

(A) *Percent Covered*
80% if provided by Delta Dental Dentists;
60% if provided by other dentists

(B) *Benefits Covered*
Construction or repair of fixed bridges, partial dentures and complete dentures are Benefits if provided to replace missing, natural teeth.

Implant surgical placement and removal and for implant supported prosthetics, including implant repair and re-cementation.

(5) Orthodontic Benefits

(A) *Percent Covered*
80% if provided by Delta Dental Dentists
80% if provided by other dentists

(B) *Lifetime Maximum*
$6,000 per Premier Plan Enrollee (Employees or Early Retirees and their eligible Dependents)
$1,500 per DPO Enrollee (Retirees and their eligible Dependents)

(C) *Benefits Covered*
Procedures using appliances or surgery to straighten or realign teeth, which otherwise would not function properly.

(d) *Benefit Limitations*

(1) Only the first two oral examinations, including office visits for observation and specialist consultations, or combination thereof, in a calendar year are Benefits while you are eligible under any Delta Dental plan.

(2) Full-mouth x-rays are a Benefit once in a five-year period while you are eligible under any Delta Dental plan. The Plan pays for a panoramic x-ray provided as an individual service only after five years have elapsed since any prior panoramic x-ray was provided under any Delta Dental plan.

(3) Bitewing x-rays are provided on request by the dentist, but no more than twice in any calendar year for children to age 18 or once in any calendar year for adults age 18 and over, while you are eligible under any Delta Dental plan.

(4) Diagnostic casts are a Benefit only when made in connection with subsequent orthodontic treatment covered under this plan.

(5) The Plan pays for two cleanings or a dental procedure that includes a cleaning each calendar year under any Delta Dental plan. Routine prophylaxes are covered as a Diagnostic and Preventive Benefit and periodontal prophylaxes are covered as a Basic Benefit.

(6) Periodontal scaling and root planing is a Benefit once for each quadrant each 24-month period.

(7) Fluoride treatments are covered twice each calendar year under any Delta Dental plan.

(8) Sealant Benefits include the application of sealants only to permanent first molars through age eight and second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within two years of its application.

(9) Crowns, Inlays, Onlays and Cast Restorations are Benefits on the same tooth only once every five years, while you are eligible under any Delta Dental plan, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

(10) Prosthodontic appliances and implants are Benefits only once every five years, while you are eligible under any Delta Dental plan, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental plan will be made if it is unsatisfactory and cannot be made satisfactory. Delta Dental will replace an implant, a prosthodontic appliance or an implant supported prosthesis you received under another dental plan if we determine it is unsatisfactory and cannot be made satisfactory. We will pay for the removal of an implant once for each tooth during the Enrollee's lifetime.

(11) The Plan will pay the applicable percentage of the dentist's fee for a standard partial or complete denture. A standard partial or complete denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth that are made from accepted materials and by conventional methods.

(12) If you select a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. The Plan will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the dentist's fee. For example: a crown where an amalgam filling would restore the tooth; or a precision denture where a standard denture would suffice.

(13) If orthodontic treatment is begun before you become eligible for coverage, payments will begin with the first payment due to the dentist following your eligibility date.

(14) Orthodontics payments will stop when the first payment is due to the dentist following either a loss of eligibility, or if treatment is ended for any reason before it is completed.

(15) The Plan will pay the applicable percentage of the Dentist's fee for a standard orthodontic treatment plan involving surgical and/or non-surgical

procedures. If the Enrollee selects specialized orthodontic appliances or procedures chosen for aesthetic considerations, an allowance will be made for the cost of a standard orthodontic treatment plan and the Enrollee is responsible for the remainder of the Dentist's fee.

(16) X-rays and extractions that might be necessary for orthodontic treatment are not covered by Orthodontic Benefits but may be covered under Diagnostic and Preventive or Basic Benefits.

(e) *Excluded Services.* Although the dental program covers many of the most commonly needed services, some services are not covered. It is important for you to know what these services are before you visit your dentist. If you are unsure whether a particular procedure is covered, or the extent to which it is covered, check with Delta Dental before proceeding. The following services are <u>not</u> covered:

(1) Services for injuries or conditions that are covered under workers' compensation or employer's liability laws.

(2) Services that are provided to the Enrollee by any Federal or State Governmental Agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except Medi-Cal benefits.

(3) Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

(4) Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such treatment are equilibration and periodontal splinting.

(5) Any Single Procedure, bridge, denture or other prosthodontic service that was started before the Enrollee was covered by this plan.

(6) Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.

(7) Procedures that are Experimental or Not Generally Accepted.

(8) Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

(9) Anesthesia, except for general anesthesia or I.V. sedation given by a licensed Dentist for Oral Surgery services and select Endodontic and Periodontic procedures.

(10) Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").

(11) Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues.

(12) Replacement of existing restoration for any purpose other than active tooth decay.

(13) Occlusal guards and complete occlusal adjustment.

(14) Charges for replacement or repair of an orthodontic appliance paid in part or in full by this plan.

(f) *Other Charges.* Benefits under this Plan are described above under the section "*Your Benefits.*" If dental services are provided by a Delta Dental Dentist or a Delta Dental PPO Dentist, you are responsible for your coinsurance only. If the dental services you receive are provided by a dentist who is not a Delta Dental Dentist or Delta Dental PPO Dentist, you are responsible for the difference between the amount the Plan pays and the amount charged by the non-Delta Dental dentist.

(g) *Covered Fees.* It is to your advantage to select a dentist who is a Delta Dental Dentist, since a lower percentage of the dentist's fees may be covered by this Plan if you select a dentist who is not a Delta Dental Dentist. Payment for services will be based on:

Delta Dental PPO Dentist: the applicable percentage of the lesser of the Fee Actually Charged, the dentist's accepted Reasonable and Customary fee on file with Delta Dental, or a fee which the dentist has contractually agreed upon with Delta Dental to accept for treating enrollees under this Plan.

Delta Dental Dentist: the applicable percentage of the lesser of the Fee Actually Charged, or the accepted Reasonable and Customary fee that the dentist has on file with Delta Dental.

California dentist or an out-of-state dentist who is not a Delta Dental Dentist, or dentists located outside the United States: the applicable percentage of the lesser of the Fee Actually Charged, or the fee that satisfies the majority of Delta Dental Dentists.

(h) *Choice of Dentists and Providers.* While covered under the PPO plan, you are free to choose any dentist for treatment. If you choose a Delta Dental PPO Dentist, you will receive all of the advantages of going to a Delta Dental Dentist, and you may have a higher level of Benefits for certain services. If you go to a non-Delta Dental Dentist, Delta Dental cannot assure you what percentage of the charged fee may be covered. A list of Delta Dental Dentists is available using the website deltadentalins.com, or by calling (888) 335-8227.

Services may be obtained from any licensed dentist during normal office hours. Emergency services are available in most cases through an emergency telephone exchange maintained by the local dental society listed in the local telephone directory. Services from dental school clinics may be provided by students of dentistry or instructors who are not licensed by the state of California.

Delta Dental Dentists have treatment forms on hand and will complete and submit the forms to Delta Dental free of charge. Claims for services from non-Delta Dental Dentists may be submitted to Delta Dental at P.O. Box 997330, Sacramento, CA 95899-7330. Dentists located outside the United States are not Delta Dental Dentists. Claims submitted by out-of-country dentists are translated by Delta Dental staff and the currency is converted to U.S. dollars. Claims submitted by out-of-country dentists for Enrollees residing in California are referred to Delta Dental's Quality Assessment department for processing. Delta Dental may require a clinical

examination to determine the quality of the services provided, and the Plan may decline to reimburse you for Benefits if the services are found to be unsatisfactory.

Delta Dental informs its panel dentists about the need for clinical precautions as recommended by recognized health authorities on the spread of HIV and other infectious diseases. However, Delta Dental cannot ensure your dentist's use of precautions against the spread of such diseases, or compel your dentist to be tested for HIV or to disclose test results to Delta Dental, or to you. If you should have questions about your dentist's health status or use of recommended clinical precautions, you should discuss them with your dentist.

(i) *Continuity of Care*

(1) Current Enrollees. Current Enrollees may have the right to the benefit of completion of care with their terminated Delta Dental Dentist for certain specified dental conditions. Please call Delta Dental's Quality Assessment Department at (415) 972-8300 to see if you may be eligible for this benefit. You may request a copy of the Delta Dental's Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Delta Dental Dentist. We are not required to continue your care with that dentist if you are not eligible under our policy or if we cannot reach agreement with your terminated Delta Dental Dentist on the terms regarding your care in accordance with California law.

(2) New Enrollees. A New Enrollee may have the right to the qualified benefit of completion of care with their non-Delta Dental Dentist for certain specified dental conditions. Please call Delta Dental's Quality Assessment Department at (415) 972-8300 to see if you may be eligible for this benefit. You may request a copy of the Delta Dental's Continuity of Care Policy. You must make a specific request to continue under the care of your current provider. We are not required to continue your care with that dentist if you are not eligible under our policy or if we cannot reach agreement with your non-Delta Dental Dentist on the terms regarding your care in accordance with California law. This policy does not apply to new Enrollees of an individual subscriber contract.

(j) *Public Policy Participation by Enrollees*. Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to: Delta Dental of California, Customer Service Department, P. O. Box 997330, Sacramento, CA 95899-7330.

(k) *Saving Money on Your Dental Bills*. You can keep your dental expenses down by practicing the following:

(1) Compare the fees of different dentists;

(2) Use a Delta Dental Dentist;

(3) Have your dentist obtain a predetermination from Delta Dental for any treatment over $300;

(4) Visit your dentist regularly for checkups;

(5) Follow your dentist's advice about regular brushing and flossing;

(6) Avoid putting off treatment until you have a major problem; and

(7) Learn the facts about overbilling. Under this Plan, you must pay the dentist your coinsurance share (see YOUR BENEFITS). You may hear of some dentists who offer to accept insurance payments as "full payment." You should know that these dentists may do so by overcharging your plan and may do more work than you need, thereby increasing plan costs. You can help keep your dental Benefits intact by avoiding such schemes.

(l) *Your First Appointment*. During your first appointment, be sure to give your dentist the following information:

(1) Your Delta Dental group number: 04874-01005 (Active) and 04874-01015 (Retiree);

(2) The Covered Plan is the San Francisco Electrical Workers Health & Welfare Plan;

(3) Primary Enrollee's ID number (which must also be used by Dependents);

(4) Primary Enrollee's date of birth; and

(5) Any other dental coverage you may have.

(m) *Accessibility and Services for After-Hours and Urgent Care*. If you or a family member has special needs, you should ask your dentist about accessibility to their office or clinic at the time you call for an appointment. Your dentist will be able to tell you if their office is accessible taking into consideration the specific requirements of your needs. Routine or urgent care may be obtained from any licensed dentist during their normal office hours. Delta Dental does not require prior authorization before seeking treatment for urgent or after-hours care. You may plan in advance, for treatment for urgent, emergency or after-hours care by asking your dentist how you can contact the dentist in the event you or a family member may need urgent care treatment or treatment after normal business hours. Many dentists have made prior arrangements with other dentists to provide care to you if treatment is immediately or urgently needed. You may also call the local dental society that is listed in your local telephone directory if your dentist is not available to refer you to another dentist for urgent, emergency or after-hours care.

(n) *Predeterminations*. After an examination, your dentist will talk to you about treatment you may need. The cost of treatment is something you may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than $300, **we encourage you to ask your dentist to request a predetermination.**

A predetermination does not guarantee payment. It is an estimate of the amount the Plan will pay if you are eligible and meet all the requirements of your plan at the time the treatment you have planned is completed.

In order to receive a predetermination, your dentist must send a claim to us listing the proposed treatment. Delta Dental will send your dentist a Notice of Predetermination which estimates how much you will have to pay. After you review the estimate with your dentist and decide to go ahead with the treatment plan, your dentist returns the statement to us for payment when treatment has been completed. Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination is issued if the Enrollee is eligible. Payment will depend on the Enrollee's eligibility and the remaining annual maximum when completed services are

submitted to Delta Dental. Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If you have any concerns about the predetermination, let us know before treatment begins so your questions can be answered before you incur any charges.

(o) *Reimbursement Provisions*

(1) Filing Your Claims. A Delta Dental Dentist will file the claim for you. You do not have to file a claim or pay the Plan's coinsurance for covered services if provided by a Delta Dental Dentist. Delta Dental of California's agreement with Delta Dental Dentists makes sure that you will not be responsible to the dentist for any money the Plan owes. If the covered service is provided by a dentist who is not a Delta Dental Dentist, you are responsible for filing the claims and paying your dentist. Claims should be filed with Delta Dental of California at P. O. Box 997330, Sacramento, CA 95899-7330 and the Plan will reimburse you. However, if for any reason the Plan fails to pay a dentist who is not a Delta Dental Dentist, you may be liable for that portion of the cost. Payments made to you are not assignable (in other words, we will not grant requests to pay non-Delta Dental Dentists directly).

(2) Services Performed Outside the U.S. Payment for claims exceeding $500 for services provided by dentists located outside the United States may, at Delta Dental's option, be conditioned upon a clinical evaluation at Delta Dental's request (see **SECOND OPINIONS**). The Plan will not pay Benefits for such services if they are found to be unsatisfactory.

The Plan does not pay Delta Dental Dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service. If you wish to know more about the method of reimbursement to Delta Dental Dentists, you may call Delta Dental's Customer Service department for more information.

(3) Payment of Completed Procedures Only. Payment for any Single Procedure that is a Covered Service will only be made upon completion of that procedure. The Plan does not make or prorate payments for treatment in progress or incomplete procedures. The date the procedure is completed governs the calculation of any Deductible (and determines when a charge is made against any Maximum) under your plan. If there is a difference between what your dentist is charging you and what Delta Dental says your portion should be, or if you are not satisfied with the dental work you have received, contact Delta Dental's Customer Service department. Delta Dental may be able to help you resolve the situation. Delta Dental may deny payment of a claim for services submitted more than 12 months after the date the services were provided. If a claim is denied due to a Delta Dental Dentist's failure to make a timely submission, you shall not be liable to that dentist for the amount which would have been payable by the Plan (unless you failed to advise the dentist of your eligibility at the time of treatment).

(4) Claims Processing. The process Delta Dental uses to determine or deny payment for services is distributed to all Delta Dental Dentists. It describes in detail the dental procedures covered as Benefits, the conditions under which coverage is provided, and the limitations and exclusions applicable to the Plan. Claims are reviewed for eligibility and are paid according to these processing policies. Those claims which require additional review are evaluated by Delta Dental's dentist

consultants. If any claims are not covered, or if limitations or exclusions apply to services you have received from a Delta Dental Dentist, you will be notified by an adjustment notice on the Notice of Payment or Action. You may contact Delta Dental's Customer Service department for more information regarding Delta Dental's processing policies.

Delta Dental uses a method called "first-in/first-out" to begin processing your claims. The date Delta Dental receives your claim determines the order in which processing begins. For example, if you receive dental services in January and February, but we receive the February claim first, processing begins on the February claim first.

Incomplete or missing data can affect the date the claim is paid. If you or your dentist has not provided Delta Dental with all information necessary to complete claim processing, payment could be delayed until any missing or incomplete data is received by Delta Dental. The order in which your claims are processed and paid by the Plan may also impact your annual maximum. For example, if a claim with a later date of service is paid and your annual maximum for the year has been reached then a claim with an earlier date of service in the same calendar year will not be paid.

(p) *If You Have Questions About Services From a Delta Dental Dentist.* If you have questions about the services you receive from a Delta Dental Dentist, we recommend that you first discuss the matter with your dentist. If you continue to have concerns, call Delta Dental's Quality Assessment department at (415) 972-8300, extension 2700. If appropriate, Delta Dental can arrange for you to be examined by one of our consulting dentists in your area. If the consultant recommends the work be replaced or corrected, Delta Dental will intervene with the original dentist to either have the services replaced or corrected at no additional cost to you or obtain a refund. In the latter case, you are free to choose another dentist to receive your full Benefit.

(q) *Second Opinions.* Delta Dental obtains second opinions through Regional Consultant members of its Quality Review Committee who conduct clinical examinations, prepare objective reports of dental conditions, and evaluate treatment that is proposed or has been provided. Delta Dental will authorize such an examination prior to treatment when necessary to make a Benefits determination in response to a request for a Predetermination of treatment cost by a dentist. Delta Dental will also authorize a second opinion after treatment if an Enrollee has a complaint regarding the quality of care provided. Delta Dental will notify the Enrollee and the treating dentist when a second opinion is necessary and appropriate, and direct the Enrollee to the Regional Consultant selected by Delta Dental to perform the clinical examination. When Delta Dental authorizes a second opinion through a Regional Consultant, the Plan will pay for all charges for the clinical examination. Enrollees may otherwise obtain second opinions about treatment from any dentist they choose, and claims for the examination may be submitted to Delta Dental for payment. The Plan will pay such claims in accordance with the Benefits of the Plan.

(r) *Organ and Tissue Donation.* Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak to your physician. Organ donation begins at the hospital when a person is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

11.2 Vision Benefits.

(a) *General Rules.* Vision benefits are available to all Covered Individuals. The Plan's vision benefits are paid directly from the Trust (*i.e.*, they are not insured). The program is administered by Vision Service Plan ("VSP"), Group #12140808. See the VSP handout for additional information.

(b) *Benefits.* Vision benefits include an eye examination and new lenses (for glasses and contacts) every 12 months, and new frames every 24 months. These benefits also include full coverage for safety frames with prescription lenses through your VSP provider, every 24 months for a $10 copay. A 20% discount on non-covered complete pairs of prescription glasses with a VSP provider is available when ordered within 12 months of your well-vision exam, or a 30% discount if ordered the same day of your well-vision exam. A complete listing of VSP participating providers is available from the Plan Office. You may also contact VSP customer service at (800) 877-7195, or visit the company's web site at vsp.com.

(c) *Coinsurance.* If you use a participating VSP provider, you must pay a $10.00 coinsurance plus additional payment for certain cosmetic or elective eyewear options.

(d) *How to Use the Plan.* Call your VSP provider to make an appointment. Identify yourself as a San Francisco Electrical Workers Health & Welfare Plan VSP member and provide your name, date of birth and Social Security number. The provider will then verify your eligibility and deal directly with VSP for reimbursement for services and materials that are covered by the Plan. You simply pay your providers for the coinsurance and any other costs that are not covered.

(e) *Out-of-Network Providers.* VSP will reimburse you up to the amount allowed under the Plan's out-of-network provider reimbursement rate if you are treated by a provider outside of the VSP network.

OUT-OF-NETWORK Maximum Benefits

Examination	$ 50.00
Single Vision Lenses	$ 50.00
Bifocal Lenses	$ 75.00
Trifocal Lenses	$ 100.00
Frame	$ 70.00 (every 24 months, effective 8/2014)
Contact Lenses	$ 105.00
Medically Necessary Contact Lenses	$ 210.00

A copy of the provider's itemized bill with all of the pertinent Plan and patient information should be submitted directly to Vision Service Plan, Attn.: Out-of-Network Claims, P. O. Box 997100, Sacramento, CA 95899-7100.

11.3 Long-Term Disability Benefit.

(a) *Eligibility.* If you are an Active Employee who becomes Totally Disabled (as defined below) while working in Covered Employment, you will become eligible to receive long-term disability (LTD) benefits under the Plan if you satisfy (i) the contribution hours requirement, (ii) the waiting period requirement and (iii) the notice and proof requirements of this section.

(1) Contribution Hours Requirement. You satisfy the contribution hours requirement if you have actually worked the following number of hours of Covered Employment in any one of the following time periods:

(A) 250 hours during the 3 months immediately preceding disability;

(B) 500 hours during the 6 months immediately preceding disability;

(C) 750 hours during the 9 months immediately preceding disability;

(D) 1,000 hours during the 12 months immediately preceding disability;

(E) 2,000 hours during the 24 months immediately preceding disability; or

(F) 3,000 hours during the 36 months immediately preceding disability.

For purposes of satisfying the hours requirement of this paragraph, you may determine the consecutive-month period on the basis of either calendar months that ended immediately before, or date-to-date months, the last of which ended on, the date preceding the date of your disability.

(2) Waiting Period Requirement. You satisfy the waiting period requirement once you have been continuously and Totally Disabled for a period of 30 days (the "Waiting Period"). Total Disability will be deemed not to have commenced before both (i) the third day that precedes the first visit with a Physician for diagnosis or treatment of the disabling condition and (ii) the day you stopped working as a result of the disabling condition. For example, if you stopped working on March 12 due to disability, but did not visit a Physician for diagnosis or treatment until March 28, your disability will not be deemed to commence until March 25. The Waiting Period, therefore, will not be satisfied until April 24.

(3) Notice and Proof Requirements. You satisfy the notice and proof requirements if you notify the Plan Office and submit an *Attending Physician's Statement* form (available from the Plan Office) no later than the later of (i) the 120th day following the date your total disability commenced or (ii) the last day of the second calendar month following the month in which the Active Employee's hour bank is exhausted. If the Active Employee provides late notice the Plan Office (such as more than two months after his or her hour bank is exhausted), the Active Employee will lose a number of monthly benefits equal to the number of months or partial months that the notice was provided late. Note that an Attending Physician Statement from Kaiser will be acceptable in lieu of the Plan's form.

Proof from your attending Physician that you continue to be Totally Disabled may be required by the Plan from time to time. The Board may designate a Physician or other medical provider to make the disability determination. If you fail to furnish proof or if you refuse to be examined by a Physician or other medical provider (as designated

and paid by the Plan), you will be deemed not to be Totally Disabled and any LTD benefits will cease.

Physician means a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) authorized to perform medical or surgical services within the lawful scope of his or her practice, and any other health care provider having substantially equivalent status under state law. (See I. Definitions)

(b) *Totally Disabled Defined.* Totally Disabled means you are unable to perform the duties of your regular occupation covered under the applicable Contribution Agreement. To be considered Totally Disabled and eligible for LTD benefits for the first 12 months of your disability, in addition to the requirements in subsection (a) above, you must be under the care of a Physician or other licensed medical provider whose medical certification of disability is recognized by the State of California for state disability income purposes. Effective February 1, 2013, you can also satisfy the definition of Totally Disabled, if the Plan Office receives proof of your (i) eligibility for or receipt of disability benefits under the California State Disability Insurance ("SDI") program; or (ii) receipt of workers compensation benefits for a temporary total disability or permanent disability. Proof requirements for LTD benefits in excess of 12 months are set forth in subsection (f)(B)(3) below.

(c) *Exclusions.* No LTD benefit payment will be paid with respect to a disability that was caused by:

(1) an intentional self-inflicted injury not resulting from a physical or mental health medical condition;

(2) the Participant's commission of, or participation in, a felony; or

(3) an act of war (whether or not declared), insurrection, rebellion, or participation in a riot or civil commotion.

(d) *Amount.* The monthly LTD benefit payment is $1,000, except as provided under the Grandfather Rule below.

Grandfather Rule: The amount of the monthly LTD benefit payment for a Participant who both received a benefit for January 2012 and has received more than 18 LTD benefit payments as of January 31, 2012, will continue to be $400 after January 2012, subject to all the conditions otherwise set forth in this section.

(e) *Commencement.* If you are eligible for an LTD benefit under subsection (a), your monthly LTD benefit will commence on the first day following the end of your Waiting Period described in subsection (a)(2), with the first payment made (if practicable) at the end of the month in which your Waiting Period ends.

(f) *Duration of Benefit*

(1) General Rule. Subject to the Grandfather Rule described in subsection (d), and earlier termination as provided in paragraph (2), the monthly LTD benefit will cease upon the earlier of (i) the date 36 monthly payments have been made and (ii) the date the Participant attains age 65. Subject to earlier termination as provided in paragraph (2), a Participant receiving an LTD benefit payment under the Grandfather Rule may continue to receive a monthly LTD benefit until attaining age 65.

(2) Early Termination of LTD Benefit. A Participant's LTD benefit will terminate before the time provided under paragraph (1) as provided in this paragraph.

(A) *Shorter Benefit for Limited Recent Service*. Your LTD benefit is limited to the number of calendar months in which at least 120 hours of Employer Contributions were required to be made on your behalf during the 36-month period immediately preceding your disability. This rule applies to all Participants, including Participants subject to the Grandfather Rule in subsection (d).

Covered Employment. Covered Employment, for purposes of this section, includes periods of registration on an IBEW Local 6 referral list. In addition, if you are an apprentice who began working in the industry less than 36 months before your disability, you will be deemed to have 36 continuous months of Covered Employment if you have been in continuous Covered Employment since you began work as an apprentice, including periods in which you were attending day school and on an employment rotation schedule established by the Joint Apprenticeship and Training Committee.

(B) *No Longer Disabled.* Your monthly LTD benefit will terminate upon the date you cease to be Totally Disabled or the date of your death. Your benefit will be appropriately prorated should your disability cease at any time other than the last day of a benefit month.

(C) *After 12 Months Requires SSA Award or Physician Extension Request.* LTD benefit payments will continue after 12 monthly payments only if (i) you have received a disability award from Social Security Administration ("SSA") and have filed a copy of the award with the Plan Office, (ii) SSA has denied your disability award solely because you lacked a sufficient number of Social Security quarters of coverage, or (iii) your Physician sends a completed *Application For Extended Long-Term Disability Benefits* form to the Plan Office certifying that (a) your Physician believes you will not be able to return to work within 6 months, (b) you are waiting for an SSA determination concerning your disability award application, or (c) it is unclear how long your disability will last (*e.g.*, the duration of your disability after a surgery may not be determinable until more time has passed after surgery to determine the surgery's success).

Note: Because the process of obtaining a disability award from SSA can often take a year or longer, you are encouraged to apply for a Social Security disability award as early in your disability as possible.

(D) *After 18 Months Requires SSA Award.* LTD benefit payments will continue after 18 months (inclusive of the 12 months in subparagraph (C) above) only if (i) you have received a disability award from SSA and have filed a copy of the award with the Plan Office or (ii) you have satisfied all of SSA's requirements for receiving a disability award, but have been denied an award solely because you lacked a sufficient number of Social Security quarters of coverage.

(E) *Denial of SSA Award.* LTD benefit payments will cease on the date that SSA has denied your application for a Social Security disability, unless you satisfied all of the requirements of the award other than having a sufficient number of Social Security quarters of coverage. You must notify the Plan Office of any denial of your SSA application within 10 days of the date of the denial.

(F) *Commencement of Pension Benefit.* LTD benefit payments will cease as of the month preceding the month that contains your pension start date under any IBEW pension plan (including any defined benefit or defined contribution plan) covering members of an IBEW local union.

(g) *Successive Disabilities*

(1) Connected Disabilities. A successive period of disability may provide for a monthly LTD benefit under this subsection that is determined without regard to the prior period of disability only if it is not connected to the prior period of disability. A successive period of disability will be considered as a continuation of, and thus connected with, a prior period of disability if it arises from (i) the same or related cause and is separated by less than 3 months of continuous Covered Employment or (ii) a different and unrelated cause and is not separated by a return to Covered Employment; but only if, in either case, the successive period of disability commences while you are either working in Covered Employment or receiving LTD benefits.

(2) No Double Payment. Regardless of the number of successive periods of disability, no month of eligibility for benefits pursuant to paragraph (1) may support more than one benefit payment.

(h) *Additional Rules*

(1) Pension Contributions. The Plan will contribute $31.25 per month to the Northern California Electrical Workers Pension Plan for any month that an LTD benefit is paid to you (or an appropriately prorated amount for a partial month's LTD benefit payment).

(2) Benefits Improperly Paid. Any benefit paid to a person not entitled thereto shall be owed by him or her to the Plan and must be repaid. Notwithstanding any other provision of this Plan, overpayments shall be deducted from future LTD benefits payable to the recipient unless the Board concludes that requiring such repayment would be inequitable.

11.4 Supplemental Parental Leave Benefit.

(a) *General Rule.* Effective January 1, 2018, the State of California requires many employers to make a state supplemental payment to eligible employees receiving a Paid Family Leave benefit (the "State Benefit") which is funded through an employee-paid payroll tax and generally provides up to 8 weeks of paid leave at 60% of the employee's average weekly wages up to a maximum amount. Participants are not eligible for the state supplemental benefit because the Inside Wire CBA waived the benefit in exchange for a similar benefit provided under this Plan. Pursuant to this section, the Plan provides a cash Supplemental Benefit to an eligible member equal to 2/3rd of the State Benefit. The State Benefit plus the Supplemental Benefit, will equal 100% of the employee's average weekly wages up to the stipulated maximum.

(b) *Eligibility.* A Participant who is a member of Local 6 is eligible for the Supplemental Benefit for any week (maximum of eight) for which the member collects a State Benefit for parental leave (child bonding) purposes, provided the member has health coverage under the Plan as of the Monday of that week. A member who is on COBRA coverage shall be treated as having health coverage. Participants receiving the Plan's Pregnancy Leave Benefit (see 11.5, below) will not be eligible for the Supplemental Parental Leave Benefit until after the Pregnancy Leave Benefit is exhausted.

(c) *Reporting.* Supplemental Benefit payments will be treated as wages for federal and state tax purposes. EISB will withhold federal income taxes at the flat supplemental withholding rate, plus social security and unemployment taxes, and will report the benefit on a separate annual Form W-2.

(d) *Funding.* Funding of the Supplemental Benefit shall be made by the hourly contributions as provided under an Employer's Contribution Agreement.

11.5 <u>Pregnancy Leave Benefit</u>.

(a) *Eligibility.* Effective January 1, 2023, a Participant who is a member of Local 6 in good standing, with current health (including COBRA) coverage under the Plan who is not working due to pregnancy or post-partum recovery, and who has collected all available California State Disability Insurance and Paid Family Leave. Participants will not be eligible for the Plan's Long-Term Disability or the Plan's Supplemental Paid Family Leave benefit during the same time period for which Pregnancy Leave benefits are paid. Eligibility for COBRA will meet the current health requirement provided the Participant is currently receiving group or individual health insurance that satisfies the minimum value coverage requirements under the Affordable Care Act.

(b) *Benefit*. The weekly Pregnancy Leave Benefit is provided for up to 20 weeks, limited to the 12-month period ending three months following the expected due date, up to the following amounts:

- $1,027 for journey-level employees
- $821.60 for apprentices (10th 6 months (80%))
- $770.25 for apprentices (9th 6 months (75%))
- $718.90 for apprentices (8th 6 months (70%))
- $667.55 for apprentices (7th 6 months (65%))
- $616.20 for apprentices (6th 6 months (60%))
- $564.85 for apprentices (5th 6 months (55%))
- $513.50 for apprentices (4th 6 months (50%))
- $462.15 for apprentices (3rd 6 months (45%))
- $410.80 for apprentices (1st 12 months (40%))

The Plan Office will process Pregnancy Leave Benefit checks on a monthly basis.

(c) *Reporting.* Pregnancy Leave Benefit payments will be treated as wages for federal and state tax purposes. EISB will withhold state and federal and payroll taxes such as social security, Medicare and unemployment insurance. Eligible Participants will receive a separate Form W-2 reporting the benefit payments and income tax withholding credits.

(c) *Funding.* Funding of the Pregnancy Leave Benefits shall be made by the hourly contributions as provided under an Employer's Contribution Agreement.

11.6 Emergency Leave Benefit.

(a) *General Rule.* In 2022, the City and County of San Francisco requires certain employers to provide leave benefits entitled the San Francisco Public Health Emergency Leave Ordinance to replace wages lost due to time off to care for Participants and/or specified family members' qualifying health-related condition due to a declared health emergency. Participants are not eligible for the San Francisco benefit because the Inside Wire CBA waived the benefit in exchange for a substantially similar benefit provided under this Plan. Pursuant to this section, the Plan provides a cash emergency leave benefit ("E-Leave Benefit"), effective January 1, 2023.

(b) *Eligibility.* A Participant who is a member of Local 6 in good standing, who is currently covered under the Plan (including COBRA) and unable to work due to one or more of the reasons listed below is eligible for the E-Leave Benefit for any workday (maximum of ten).

(i) You are recommended or required by a federal, California state, or San Francisco health order relating to a public health emergency, to take leave from work.

(ii) Your healthcare provider advises that you isolate or quarantine due to a public health emergency.

(iii) You have symptoms of, and are seeking or have received a positive medical diagnosis for, a possible infectious, contagious or communicable disease associated with a public health emergency.

(iv) You are caring for a family member with any of the above conditions or, due to a public health emergency, whose school or place of care has been closed or health provider is unavailable, due to a public health emergency.

(v) There is an air quality emergency, you primarily work outdoors and you (i) are diagnosed with heart or lung disease, (ii) have been previously diagnosed by your Physician with respiratory problems such as asthma, emphysema, and chronic obstructive pulmonary disease, (iii) are pregnant, or (iv) are age 60 or older.

(c) *Definitions.* For purposes of the E-Leave Benefit, the following definitions apply.

(i) "Public health emergency" means a local or statewide health emergency relating to a contagious, infectious, or communicable disease declared by the City's local health officer or the state health officer pursuant to the California Health and Safety Code, or a day when the Bay Area Air Quality Management District issues a Spare the Air Alert.

(ii) "Family member" means a Child, grandchild, grandparent, parent, sibling, Spouse or Domestic Partner.

(d) *Reporting.* E-Leave Benefit payments will be treated as wages for state and federal tax purposes. EISB will withhold state and federal and payroll taxes such as social security, Medicare and unemployment insurance. Eligible Participants will receive a separate Form W-2 reporting the benefit payments and income tax withholding credits.

(e) *Funding.* Funding of the E-Leave Benefit shall be made by the hourly contributions as provided under an Employer's Contribution Agreement.

11.7 Death Benefit.

(a) *General Rules.* If you have not attained the age of 62 and you die while you are covered (i) as an Active Employee (ii) as an Early Retiree (see Section 4.3), (iii) during the first 6 months of no-cost disability coverage (see Section 3.6(b)) (iv) during the first 12 months of COBRA Coverage or (v) while performing Military Service (see Section 6.8), your beneficiary will be paid $50,000 directly from the Plan's assets. If your death results from an accident, your beneficiary will be paid an additional $50,000. You may name anyone you wish as your beneficiary, and you may change your beneficiary at any time, but you must complete a beneficiary form approved by, and filed with, the Plan Office. Your beneficiary will be named or changed as of the date an executed beneficiary designation form or change of beneficiary form is received in the Plan Office. The form must be received before your death to be effective. If your beneficiary is under the age of 18 at the time death benefits are to be paid, the Plan will disburse the death benefit only to such individual who has been appointed by a court as the guardian of the minor beneficiary.

(b) *Effect of Divorce on Beneficiary Designation.* Any designation of your Spouse or Domestic Partner as a Beneficiary becomes ineffective upon your divorce from such Spouse or Domestic Partner, unless the designation expressly provides that it shall remain effective notwithstanding such divorce.

(c) *No Beneficiary Designation.* If no living beneficiary is designated upon your death, your death benefit will be payable pursuant to the following hierarchy: first to your surviving Spouse or Domestic Partner, then to your surviving children in equal shares, then to your surviving parents in equal shares, and finally to your estate.

(d) *Definition of Accident*. For purposes of this section, "accident" means a sudden, violent, unexpected, external incident, and expressly excludes natural causes, intentional self-inflicted injury and any reckless disregard for personal safety.

XII. CLAIM AND APPEAL PROCEDURES

12.1 Claims and Appeals for Self-Funded PPO, Dental, Vision, LTD and Other Noninsured Benefits. If you believe you are entitled to Self-Funded PPO benefits (Article VIII), dental benefits (Section 11.1), vision benefits (Section 11.2), long-term disability benefits (Section 11.3), death benefits (Section 11.7) or other non-insured benefits under the Plan, and the Plan refuses to provide these benefits to you, you should file a claim for benefits (and potentially an appeal, if that claim is denied) in accordance with the claim and appeal procedures described in Appendix C. The claim and appeal procedures of the HMOs do not apply to benefit claims relating to benefits described in the preceding sentence. Because the passage of time may limit or eliminate your right to claim benefits, do not delay filing a claim if you believe benefits are owed to you that the Self-Funded PPO has refused to pay.

12.2 Claims and Appeals for HMO Benefits. If you believe you are entitled to benefits from the Kaiser HMO or the Blue Shield HMO that the HMO refuses to provide to you, you should file a claim for benefits (and potentially an appeal, if your claim is denied) in accordance with that HMO's claim and appeal procedures. The Plan Office can provide you the claim and appeal procedures for each of these HMOs, or you can obtain them directly from the HMO. The claim and appeal procedures in Appendix C do not apply to benefit claims under the HMOs. The Board has no role in the determination of HMO benefits. Because the passage of time may limit or

eliminate your right to claim benefits, do not delay filing a claim if you believe benefits are owed to you that an insurer has refused to pay.

12.3 Eligibility Determinations. If you believe you are eligible to participate in the Plan and the Plan has refused to allow your participation, you may submit a claim directly to the Plan Office, in writing, explaining why you believe you are eligible to participate in the Plan. Your eligibility claim will be considered at the next regularly scheduled meeting of the Board. The claim and appeal procedures in Appendix C and for the HMOs do not apply to eligibility claims.

XIII. MISCELLANEOUS PROVISIONS

13.1 Basic Plan Information.

Name of Plan	San Francisco Electrical Workers Health & Welfare Plan
Plan Number	501
Federal Identification Number	94-6061762
Plan Year-End	January 31
Type of Plan	Employee welfare benefit plan
Plan Administrator	Board of Trustees of the San Francisco Electrical Workers Health & Welfare Trust
Names and Addresses of Trustees	(See Appendix E)
Contract Administrator	EISB 720 Market Street, Suite 700 San Francisco, CA 94102-2509 Tel: (415) 263-3670
Agent for Service of Legal Process	Nancy Finegan (at EISB)

13.2 Construction. The validity of the Plan or any of its provisions will be determined under and construed according to ERISA and other federal laws and, to the extent applicable, the laws of the State of California. The Plan is intended to be construed as a whole, 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.

13.3 No Vested Right. Nothing in this Plan shall be construed as giving Participants or any other individual a vested right to continued Plan coverage. The Board may require new or greater coinsurance and/or may change the eligibility requirements and any other Plan rules at any time.

13.4 Facility of Payment. Any death benefit payable to a minor may be paid to the legally appointed guardian of the minor or, if there is no such guardian, to such adult or adults as

have complied with the requirements of California or other applicable law for receipt of such benefit on behalf of the minor, after which the Plan shall have no further obligations with respect to such minor.

13.5 Available Assets for Benefits. Plan benefits can be paid only to the extent the Plan has adequate resources. No Contributing Employer has any liability, directly or indirectly, to provide Plan benefits beyond the obligation set forth in the Contribution Agreement. Should the Plan have insufficient assets to permit the continued payment of benefits, nothing contained in this Plan shall be construed as obligating any Contributing Employer, Local 6 or the IBEW to make benefit payments or additional contributions beyond what is required by the Contribution Agreement. There is no liability upon the Trustees, individually or collectively as the Board, or upon any other person or entity of any kind, to provide Plan benefits.

13.6 Incompetence and Incapacity. If the Board determines that a Covered Individual is incompetent or incapacitated and no guardian has been appointed, or if a Covered Individual 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 Individual, pay any amount otherwise payable to the Covered Individual to the Covered Individual's Spouse, Domestic Partner, or blood relative or any other person determined by the Board to be equitably entitled thereto. In the event benefits are payable to a deceased Covered Individual, the Plan shall pay the benefits, in the priority stated with multiple members of each class sharing equally, to the Covered Individual's surviving Spouse or Domestic Partner, children, parents, siblings, then the Covered Individual's estate. Any payment in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

13.7 Gender and Number. Wherever applicable, the masculine pronoun as used herein shall include the feminine and the singular the plural.

13.8 Mistaken Payments. If the Plan mistakenly makes a payment to any person or otherwise causes an administrative error relating to the Plan, the Plan will correct the error to the extent practicable, and any person to whom such mistaken payment was made will repay the Plan upon request of the Plan. The Plan has the right to recover any amount mistakenly or improperly paid to any person, and the Plan may offset any benefit payable to, or with respect to, a Covered Individual or beneficiary by any other amounts owed to the Plan by such Covered Individual, regardless of whether the reason for the need for the offset relates to the same benefit as that which is being offset.

13.9 Loss of Benefits and Other Consequences. Under some circumstances, including without limitation those circumstances set forth in this section, a Covered Individual may lose benefits, have payments delayed, or become liable to the Plan.

(a) *Inadequate or Improper Evidence.* The Board has the power to deny, suspend or discontinue benefits to a Participant who fails to submit, at the request of the Plan Office, information or proof reasonably required to administer the Plan.

(b) *Prohibited Employment in the Electrical Industry.* If after your retirement you engage in prohibited employment as described in Sections 3.1(c)(2) or 4.7(a), your entitlement to Plan benefits will be suspended.

(c) *No or Incomplete Enrollment.* No benefits are payable with respect to a Covered Individual until the Covered Individual is properly and timely enrolled in the Plan.

(d) *Providing Incomplete or False Information.* If a Covered Individual fails to provide requested information or gives false information to verify disability, age, beneficiary information, marital status or other vital information, payment of benefits may be delayed or go unpaid. If a Covered Individual makes a false statement to the Plan or other official regarding the payment of benefits or other issues related to the Plan, he will be liable to the Plan for any benefits paid in reliance on such false statements or information, and any attorney fees and costs incurred in effecting recovery or which were incurred as a result of the false statement or information, and reasonable interest charges. The Plan may deduct any such fees, costs and interest charges from any benefits otherwise payable with respect to the Covered Individual.

(e) *Subrogation and Related Claims.* The Plan may recover any amount it pays for claims for which a Covered Individual received payment under a court judgment, settlement agreement, insurance payment or any other form of payments from a third party, including any payment received from an insurance company. (See also Section 8.13.)

13.10 Organizations that Receive Premiums. The following organizations receive insurance premiums from the Plan to provide insured benefits:

(1) Union Labor Life Insurance Co. (stop-loss coverage for Self-Funded PPO)

(2) Blue Shield of California (HMO)

(3) Kaiser Foundation Health Plan, Inc. (HMO)

13.11 Method of Funding. The Plan is funded by contributions to the Plan's Trust by the Contributing Employers in accordance with the Contribution Agreements. Participants and Beneficiaries may request whether a specific employer contributes to the Plan, and any Contributing Employer's address. In addition to Employer Contributions, some Covered Individuals (including certain Retirees and COBRA beneficiaries) are required to make payment to the Plan in order to maintain coverage for benefits.

13.12 Rescission of Plan Coverage. A Covered Individual's coverage under the Plan may be canceled or discontinued with retroactive effect ("rescinded") by the Board, upon at least 30 days advance notice, if the Covered Individual (or the Participant with respect to the Covered Individual) has engaged in fraud or made an intentional misrepresentation of material fact to the Plan. Any such rescission shall be made consistent with Treasury Regulation §54.9815-2712 (or any successor rule). A rescission is treated by the Plan as the denial of a claim, and is subject to the claims procedures set forth in Appendix C. In the event of a rescission of coverage of a Participant, the coverage of any Dependent of the Participant that is not connected to the fraud or misrepresentation shall not be rescinded, but will cease prospectively under the general requirements of Article V.

13.13 Temporary Relief Provisions. Due to the Coronavirus pandemic, the Plan has provided several forms of relief to its members, including but not limited to continuation coverage, waiver of out-of-pocket costs for testing and treatment, relaxed refill requirements on maintenance prescriptions, and waived copays for Teladoc services. These provisions will remain in effect through November 11, 2023. In addition, deadlines for special enrollment; electing COBRA coverage; making COBRA monthly coverage payments; notifying the Plan of a qualifying event or determination of disability; filing a claim; filing an appeal of an adverse benefit determination; filing a request for an external review after adverse benefit determination; and filing information to perfect a request for an external review have also been extended. These deadline extensions will

terminate July 9, 2023. More information can be found in the specific Summary of Material Modification.

XIV. STATEMENT OF ERISA RIGHTS

14.1 Your Rights Under ERISA. As a Participant you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

(1) Examine, without charge, at the Plan Office and at other specified locations such as work sites and the Local 6 office, documents governing the Plan, including the Collective Bargaining Agreement and the annual report (Form 5500 series) filed with the Department of Labor.

(2) Obtain copies of Plan documents and other information (which is required by law to be furnished) upon written request to the Plan. The Plan Office may require that you pay a reasonable charge for the copies.

(3) Receive a summary of the Plan's annual financial report, known as a Summary Annual Report ("SAR"). The Plan is required by law to furnish each Participant with a copy of the SAR.

(4) Continued health care coverage for yourself and your Dependents if there is a loss of coverage under this plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage.

(5) Review this document and other documents governing your COBRA continuation coverage rights.

(6) Reduction or elimination of exclusionary periods of coverage for pre-existing conditions if you have creditable coverage from another plan. The Plan will provide you a Certificate of Creditable Coverage, without charge, when you lose coverage or become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, or when you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

14.2 Prudent Actions by Plan Fiduciaries. In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries," have a duty to do so prudently and in your interest and the interest of other Participants and Dependents. No one, including your Employer, Local 6, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

14.3 Enforcing Your Rights. If your claim for a Plan benefit is denied in whole or in part, you have a right to know why it was denied, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time limits. Under ERISA, there are steps you can take to enforce these rights. For instance, if you request a copy of certain Plan documents (required to be furnished) or the latest annual report (Form 5500) from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Board or the Board's delegate. If you have a Claim for benefits which is denied or

ignored, in whole or in part, and which is upheld on appeal (or ignored), you may file suit in a state or federal court. As summarized earlier in this document, any lawsuit must be filed within two years of the denial on appeal or other action, omission or decision which adversely affected you or your benefits. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a QMCSO under Section 5.3, you may file suit in federal court. If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these court costs and fees. If you lose (for example, if it finds your claim is frivolous), the court may order you to pay these costs and fees.

14.4 Assistance with Your Questions. If you have any questions about the Plan, you should contact the Plan Office. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at (800) 998-7542 or contact the EBSA field office nearest you. You may find answers to your questions and a list of EBSA offices at http://www.dol.gov/ebsa/welcome.html.

APPENDIX A
Contribution Agreements and Other Agreements
as of February 1, 2021

A copy of any document referenced in this appendix is available upon request of the Participant, Beneficiary, Employer or other person to whom the document might reasonably apply by reason of their respective status.

I. Collective Bargaining Agreements
   - (a) Inside Wire Agreement (Eff. 6/1/2018)
   - (b) Residential Agreement
   - (c) Material Handlers Agreement
   - (d) San Francisco Housing Authority

II. Subscription Agreements
   - (a) Joint Apprenticeship & Training Committee (JATC)
   - (b) IBEW Local 6 (Eff. 1/1/11)

III. Other Agreements
   - (a) Electrical Industry Health and Welfare Reciprocal Agreement (Eff. 1986)

APPENDIX B
Monthly Coverage Payment Schedules
as of February 1, 2022

Early Retirees Ages 55 through 62	
Health Plan	Monthly Payment
Kaiser	$ 2,455.00
Blue Shield HMO	$ 2,649.00
Self-Funded PPO	$ 2,582.00
Early Retirees Ages 62 through 64 Who Have Already Satisfied Service Requirements to Qualify as a Regular Retiree at age 62 or Rule of 85 (Section 4.3(d))	
Health Plan	Monthly Payment
Kaiser	$ 856.00
Blue Shield HMO	$ 856.00
Self-Funded PPO	$ 856.00
Early Retirees Ages 62 through 64 Who Must Continue Participation as an Early Retire to Qualify as a Regular Retiree at age 62 (Section 4.3(c)	
Health Plan	Monthly Payment
Kaiser – Single	$ 982.00
Kaiser – Family	$ 1473.00.00
Blue Shield HMO – Single	$ 1,060.00
Blue Shield HMO - Family	$ 1,589.00
Self-Funded PPO – Single	$ 1,033.00
Self-Funded PPO - Family	$ 1,549.00

Regular Retirees Age 65 and older, Early Retirees Having Reached Age 65 and Older, Disabled Retirees, Surviving Spouses or Domestic Partners -- All Plans	
Age	Monthly Payment
Under Age 65	$ 737.00
Ages 65 through 74 and retirees who attain age 75 on or after 1/1/2008;	Single: $ 295.00 Family: $ 590.00
Retirees who attained age 75 before 1/1/2007	$ 0.00

APPENDIX C
San Francisco Electrical Workers Health & Welfare Plan
Claim and Appeal Procedures for Non-HMO Benefits

C.1 *General Rules*

(a) *Applicability of These Procedures.* These procedures apply to any claim for Plan benefits other than the Kaiser HMO, the Blue Shield HMO and any benefit provided under an insurance policy. A claim for dental or vision benefits under the Plan is treated the same as a Self-Funded PPO Claim under these procedures.

(b) *Overview and Where to Submit a Claim.* A claim for benefits is considered to have been filed when it is received by the Plan Office, provided it is substantially complete with all necessary documentation. If the documentation is not substantially complete, the Claimant will be notified as soon as is practicable of what information or documentation is necessary to complete the claim. A claim must be filed within 24 months from the date of treatment. In- and Out-of-Network PPO claims should be sent directly to Blue Shield at P.O. Box 272540, Chico CA 95927. Dental claims for services from non-Delta Dental dentists should be submitted to Delta Dental at P.O. Box 997330, Sacramento, CA 95899-7330. Vision service claims for services from non-VSP providers should be submitted to Vision Service Plan, Attn.: Out-of-Network Claims, P. O. Box 997100, Sacramento, CA 95899-7100. Other claims should be sent directly to the Plan Office at 720 Market Street, Suite 700, San Francisco, CA 94102-2509; Tel: (415) 263-3670.

(c) *Medicare Eligible Individuals.* Medicare-eligible Covered Individuals should have their Hospital and Physicians submit claims with the Medicare Explanation of Benefits Worksheet to Blue Shield after Medicare has made payment.

(d) *Casual and General Inquiries.* These procedures do not apply to casual or general inquiries regarding eligibility or specific Plan benefits. In order for a claim to constitute a claim for benefits that invokes these procedures, the Claimant must submit a written claim for benefits to either Blue Shield or the Plan Office in accordance with Section C.3. Submission of such a written claim invokes these procedures.

(e) *HMO and Other Insured Claims.* A Claimant who wishes to make a claim for benefits under the Kaiser HMO, the Blue Shield HMO, or any group insurance policy must follow the claims procedures under the applicable HMO contract or insurance policy that applies to that benefit. This policy does not apply to HMO or insured benefits.

(f) *Named Fiduciary.* For purposes of determining the amount of or entitlement to benefits under Section C.3 of these procedures, the Plan Office, with assistance from Blue Shield, is the named fiduciary with full power to make factual determinations for the Plan and interpret and apply the Plan's terms as they relate to the claim. The Plan Office will decide a claim in accordance with these procedures and may obtain independent medical advice and require such other evidence as it deems necessary to decide the claim. If the Plan Office denies a claim, in whole or in part, the Claimant will receive written notification setting forth the reason(s) for the denial. Claimant may appeal to the Board for a review of the denied claim, and the Board will decide the appeal in accordance with these procedures consistent with ERISA.

(g) *Authorized Representative.* An authorized representative, such as a Spouse, Domestic Partner or adult child, or a service provider, may submit a claim or appeal on behalf of a Claimant if the Claimant has previously designated the person to act on the Claimant's behalf, provided the designation is reasonably clear to the Plan Office. The Plan Office may request additional information to verify that the designated person is authorized to act on the Claimant's behalf.

C.2 Definitions

For the purposes of these procedures, the following capitalized terms have the following meanings unless otherwise specified herein.

"Claimant" means a Covered Individual, or such individual's representative or health care provider who is designated by such individual to act on his behalf, who submits a claim under these procedures.

"Complete Claim" means a claim that contains all of the necessary information and supporting documentation, if applicable, to render a decision on the claim and is submitted within the prescribed timeframe under these procedures.

"Concurrent Care Claim" means a claim to continue (i) a previously approved course of treatment under the Self-Funded PPO for a specific time period or number of treatments that has been reduced or terminated before the end of the approved course of treatment or (ii) a course of treatment beyond the specific time period or number of treatments previously approved under the Self-Funded PPO.

"Denial" or **"Denied"** means a denial, reduction, termination of, or failure to provide or make payment for, in whole or in part, a claimed benefit.

"Disability Claim" means a claim for a disability benefits under the Plan.

"Other Claim" means a claim that is neither a PPO Claim, a Disability Claim nor a claim to which an HMO's or an insurer's procedures apply, and includes a claim for Plan eligibility.

"Pre-Service Claim" means a claim for benefits for which the Plan requires Claimant to obtain authorization before services are provided or received by Claimant.

"Post-Service Claim" means a claim for a benefit under the Self-Funded PPO for reimbursement or consideration of payment for the cost of medical care that has already been rendered, and that is not a Concurrent Care Claim. It includes a claim relating to rescission of coverage.

"PPO Claim" means an In- or Out-of-Network claim under the Self-Funded PPO that is either a Post-Service Claim or a Concurrent Care Claim. A claim for dental or vision benefits is treated as a Self-Funded PPO Claim for purposes of these procedures.

C.3 Initial Claim Procedure and Time Limits

A Covered Individual who wishes to object to the rejection, by Blue Shield, Magellan or Beat It on behalf of the Self-Funded PPO, by Delta Dental or by VSP, of a request to provide a benefit, should file an initial claim for benefits with the Plan Office under this section. A Covered Individual may, in the alternative, submit a PPO claim to Blue Shield, though Blue Shield will generally forward the claim on to the Plan Office for

determination. Such a claim will be decided by the Plan Office within the applicable timeframe under these procedures, regardless of whether all information required to perfect the claim is included. The timeframe for decision begins upon receipt of the claim by the Plan Office and depends upon the type of claim submitted, whether the claim is complete or incomplete, whether additional information is required and whether an extension is required to make a decision on the claim. The Plan Office may not suspend a claim on the basis that the claim submission is incomplete without approval from the Claimant. For some claims, Blue Shield will make the initial determination in order to expedite the claim.

(a) Urgent Care Claim.

(1) If an Urgent Care Claim is submitted complete, the Plan Office shall render a decision within 72 hours after receipt of the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. If the Claimant fails to provide sufficient information, the Plan shall notify the Claimant within 24 hours after receipt of the claim of the specific information necessary to complete the claim. The Claimant shall be afforded at least 48 hours to provide the specified information. Thereafter, the Plan will notify the Claimant of its benefit determination no later than 48 hours after the earlier of: (i) the Plan's receipt of the specified information, or (ii) the end of the period afforded to the Claimant to provide the specified additional information.

(2) Any Urgent Care Claim that requests to extend the course of treatment beyond the period of time or number of treatments, shall be decided within 24 hours after receipt of the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the initially approved period.

(3) If the Claimant fails to follow the proper procedure for filing an Urgent Care Claim, the Claimant will be notified of the failure and the proper procedures to be followed to file a claim within 24 hours after the Plan's receipt. The Claimant may be notified orally, unless written notification is requested. The Claimant will receive notice if the claim or communication fails to include any of the following information: (i) the name of the specific claimant; (ii) a specific medical condition or symptom, and (iii) a specific treatment, service or product for which Plan approval is requested.

(4) If an Urgent Claim is denied, notice of the claim decision may be furnished orally within 72 hours after receipt of the claim or within 48 hours after receipt of the specified additional information, and will be followed by a written or electronic notification containing applicable notification information as required under ERISA no later than 3 days after the oral notification to the Claimant.

(b) Pre-Service Claim

(1) If a Pre-Service Claim as submitted is complete, the Plan Office shall render a decision within 15 days from the date the Complete Claim is received by the Plan. The Plan Office may extend this time period by 15 additional days, if the Claimant is notified of the need for such extension before the expiration of the initial 15-day decision period. Notification of the extension shall include the reason for the extension, an approximate decision date and other applicable notification information as required under ERISA.

(2) If a Pre-Service Claim as submitted is incomplete, the Plan Office shall notify the Claimant within 15 days of receiving the incomplete claim. Such notice may request additional information required to render a decision on the claim and explain why such information is necessary. The notice will suspend the 15-day time period to render a decision. The Claimant shall be afforded 45 days to provide the requested information. If the requested information is not received within this time period, then the Plan Office will render a decision at the end of the 45-day period. If the requested information is received before the end of the 45-day period, the suspension on the time frame for decision is lifted and the Plan Office will render a decision within the time remaining of the initial 15-day period, subject to permissible extension.

(3) If the Claimant fails to follow the proper procedure for filing a Pre-Service Claim, the Claimant will be notified of the failure and the proper procedures to be followed to file a claim within 5 days after the Plan's receipt. Claimant may be notified orally, unless written notification is requested. The Claimant will receive notice if the claim or communication fails to include any of the following information: (i) the name of the specific claimant; (ii) a specific medical condition or symptom, and (iii) a specific treatment, service or product for which Plan approval is requested.

(c) Post-Service Claim

(1) If a Post-Service Claim as submitted is complete, the Plan Office shall render a decision (i) within 30 days from the date the Complete Claim is received from Blue Shield or (ii) 60 days from the date the Claimant submitted the Complete Claim to Blue Shield. The Plan Office may extend this time period by 15 additional days, if the Claimant is notified of the need for such extension before the expiration of the initial 30-day decision period. Notification of the extension shall include the reason for the extension, an approximate decision date and other applicable notification information as required under ERISA.

(2) If a Post-Service Claim as submitted is incomplete, the Plan Office shall notify the Claimant within 30 days of receiving the incomplete claim. Such notice may request additional information required to render a decision on the claim and explain why such information is necessary. The notice will suspend the 30-day time period to render a decision. The Claimant shall be afforded 45 days to provide the requested information. If the requested information is not received within this time period, then the Plan Office will render a decision at the end of the 45-day period. If the requested information is received before the end of the 45-day period, the suspension on the time frame for decision is lifted and the Plan Office will render a decision within the time remaining of the initial 30-day period, subject to permissible extension.

(3) If a Post-Service Claim is denied, notice of the claim decision shall be furnished promptly to the Claimant, shall be written in a manner understandable to the Claimant and shall contain applicable notification information as required under ERISA.

(d) Concurrent Care Claim

(1) If a Concurrent Care Claim requesting an extension of a course of treatment is submitted, the Plan Office shall render a decision according to the Post-Service Claim procedures.

(2) In the event a Claimant's pre-approved course of treatment for a specific time period or specific number of treatments is reduced or terminated before the end of such treatment, the Claimant must be notified of the reduction or termination by the Plan Office and be given a reasonable period of time to appeal the decision before the treatment is reduced or eliminated. The Plan Office shall render a decision before the previously approved treatment is reduced or terminated.

(3) If a Concurrent Care Claim is denied, notice of the claim decision shall be furnished promptly to the Claimant, shall be written in a manner understandable to the Claimant and shall contain applicable notification information as required under ERISA.

(e) Disability Claim

(1) A Disability Claim must be submitted to the Plan Office within 90 days after the date of the onset of the disability. The Plan Office will decide on a completed Disability Claim and notify the claimant of the decision within 45 days after receipt of the Claim by the Plan Office.

(2) The Plan Office may under special circumstances extend this time period by 30 additional days if the Claimant is notified of the need for such extension before the expiration of the initial 45-day period. The Plan Office may under special circumstances extend the initial extension period by an additional 30 days if the Claimant is notified of the need for such additional extension before the expiration of the initial 30-day extension. Notification of any extension shall include the reason for the extension, an approximate decision date, and other applicable notification information as required under ERISA.

(3) If a Disability Claim as submitted is incomplete, the Plan Office may notify the Claimant within 45 days of receiving the incomplete claim. The notice may request additional information required to render a decision on the claim and explain why such information is necessary. The notice will suspend the 45-day time period to render a decision, and the Claimant shall be afforded 45 days to provide the requested information. Subject to the Plan Office's ability to extend the decision period as described in the preceding subparagraph, if the requested information is not received within this time period, then a decision will be rendered at the end of the initial 45-day period, and if the requested information is received before the end of the 45-day period, the suspension on the time frame for decision is lifted and a decision will be rendered within the time remaining of the initial 45-day period, subject to permissible extension.

(4) Notice of a claim decision shall be furnished promptly to the Claimant, shall be written in a manner understandable to the Claimant, and shall contain applicable notification information as required under ERISA.

(f) Other Claims

(1) Unless otherwise provided in the preceding subparagraphs, the Plan Office shall render a decision on a claim not otherwise described above (such as a claim for Plan eligibility) in accordance with either Pre-Service or Post-Service claims, as appropriate.

(2) If the claim is denied, notice of such decision shall be furnished promptly to the Claimant, shall be written in a manner understandable to the Claimant, and shall contain applicable notification information as required under ERISA.

C.4 Notification of Initial Claim Decision

(a) *General Rules.* Upon making a claim determination, the Plan Office shall provide the Claimant with written or electronic notice of the claim determination to the extent required under ERISA, that includes those items listed in subsection (b), as applicable, and shall be written in a culturally and linguistically appropriate manner.

(b) *Contents of Notice.* Notice provided to a Claimant of a claim determination shall contain:

(1) information sufficient to identify the claim involved, including the date of service, health care provider, claim amount, diagnosis code (and meaning), and treatment code (and meaning);

(2) the specific reason(s) for the denial;

(3) a reference to the specific Plan provisions upon which the denial was based;

(4) a description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary (if applicable);

(5) a description of the appeal procedures and the time limits applicable to appealing the claim decision;

(6) a statement of the Claimant's right to bring legal action under ERISA;

(7) an explanation of any internal rule, protocol, procedure, guideline, or other criterion upon which the denial was based or a statement that explains the Claimant's right to receive a copy of such information free of charge upon request; and

(8) if the denial was based on Medical Necessity, experimental treatment or similar exclusion or limit, the notice shall contain either (i) an explanation of the clinical or scientific judgment for making such decision, applying the terms of the Plan to the Claimant's medical condition, or (ii) a statement that such explanation is available free of charge upon request.

(c) *Additional Contents of Notice.*

(1) Urgent care claims. In addition to the contents listed in subsection (b), a claim determination concerning urgent care shall include a description of the expedited review process applicable to such claims.

(2) Disability Claims. In addition to the notice requirements listed in subsection (b) above, a claim determination with respect to disability benefits will include:

(A) Discussion of the decision, including an explanation of the basis for disagreeing with or not: (i) the views presented by the Claimant to the Plan of health care professionals treating Claimant and vocational professionals who evaluated the Claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination; and (iii) the Social Security Administration disability determination presented by the claimant to the Plan, if any.

(B) In the event no rule, protocol, procedure, or standard under section C.4(b)(7) exists, the Plan will provide a statement notifying the Claimant of the lack of existence.

(C) The Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Claimant's claim for benefits.

C.5 Appeal Procedures

(a) *Commencement of Appeal and Disclosure of Information*

(1) If a Claimant's initial claim for benefits is wholly or partially Denied, the Claimant may voluntarily request a review on appeal by the Board of the Denial. The Claimant must complete all of the administrative review steps available through the Plan Office under Section C.3 before an appeal to the Board is permitted under this Plan. Any request for a review on appeal made by a service provider shall not be treated as an appeal subject to these procedures unless such request is clearly on behalf of, and authorized by, a Claimant.

(2) Written requests for review of a Denied Self-Funded PPO Claim or Disability Claim on review must be made within 180 days of the Denial (60 days for Other Claims) and must include the Claimant's name and identification number from the ID card, the date(s) of service(s), as applicable, the provider's name, as applicable, a copy of the Denial letter(s), and the basis of the appeal. The Claimant may submit additional comments, documents, written evidence, written testimony, records and other materials with his or her written request for appeal.

For a claim involving Urgent Care, a Claimant may make an oral or written request for an expedited appeal. All necessary information shall be transmitted by telephone, facsimile, or other available similarly expeditious method.

(3) Within 15 days of the receipt of the appeal, the Plan Office will provide written communication (such as an acknowledgement) indicating receipt of the appeal. The Plan shall, free of charge, provide the Claimant with reasonable access to, and copies of, all documents, records and other information relevant to the appeal. Relevant information means information (i) relied upon in the initial benefit claim determination, (ii) submitted, considered or generated in the course of the initial benefit claim determination, or (iii) that constitutes a statement of policy or guidance with respect to the Plan concerning the Denial, regardless of whether it was relied upon in making the benefit determination, and (iv) that demonstrates compliance with the administrative processes and safeguards required in making the determination. In addition, the Plan will provide the Claimant, free of charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim, and any new or additional rationale that will be a basis for any final internal Denial. Such evidence and rationale will be provided as soon as possible and sufficiently in advance of the final decision so as to give the Claimant a reasonable opportunity to respond prior to the decision.

(4) If a medical or vocational expert was consulted in connection with the Claimant's initial claim, the expert will be identified, regardless of whether the expert's opinion was used to render the initial claim decision. If a medical or vocational expert is consulted

during the course of the appeal, the expert consulted on appeal shall be different than, and not a subordinate of, the expert consulted during the initial claim process.

(5) A claim on appeal will be given a full and fair review by the Board and shall include a review of all materials used to reach the initial claim decision; however, deference shall not be given to the initial claim decision. If the appeal is related to clinical maters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination.

(b) *Deadlines for Decision on Appeal*

(1) Upon timely receipt of a Claimant's request for review on appeal, the Board will evaluate the claim and make a final determination within the following determination periods, which shall begin to run upon the Plan Office's receipt of the appeal regardless of whether or not all information required to perfect the claim is included in the Claimant's request for review on appeal:

Type of Claim	**Appeal Determination Period**
Concurrent Care Claim	See (2) below
Disability Claim	See (4) below
Pre-Service Claim	30 Days
Post-Service Claim	See (4) below
Other Claim	See (3) below
Urgent Care Claim	72 hours

(2) With respect to Concurrent Care Claims, if an on-going course of treatment was previously approved for a specific period of time or number of treatments, and the Claimant requests to extend treatment, the Claimant's request will be considered a new claim and decided according to Post-Service timeframes.

(3) The Board may not extend the time period for decision on a PPO Claim appeal unless the Claimant voluntarily agrees to such extension. With respect to Disability Claims Post-Service, and Other Claims, the Board, under special circumstances, may extend the appeals determination period by a number of days equal to the number of days included in the initial appeals determination period, provided the Claimant is notified of the extension prior to the end of the initial appeals determination period, and the Board includes in such notice the reason for the extension and an estimate of the date on which the appeal determination will be made.

(4) Ordinarily, a decision on the appeal of a Post Service Claim or a Disability Claim will be made at the next regularly scheduled meeting of the Board following receipt of Claimant's request for review (or the second following regularly scheduled meeting in the case of a request for review that is received within 30 days before the next regularly scheduled meeting). In special circumstances, a delay until the following regularly scheduled meeting may be necessary. The Claimant will be advised in writing in advance if this extension will be necessary. Once a decision on review of the claim has been reached, the Claimant will be notified of the decision generally within 5 days after the decision has been reached.

(c) *Notice of Determination on Appeal.* Upon denying an appeal, the Board shall provide the Claimant written or electronic notice of the claim determination, which shall

be written in a culturally and linguistically appropriate manner, and which, if Denied, shall contain:

(1) the specific reason(s) for the Denial;

(2) a reference to the specific Plan provisions upon which the Denial was based;

(3) a statement that the Claimant is entitled to receive, free upon request, copies of and reasonable access to documents, records and other information relevant to the claim;

(4) a statement describing any voluntary appeal procedure, if available, and the right to obtain information regarding such procedure, as well as a statement of the Claimant's right to bring legal action under ERISA;

(5) an explanation of any rule, protocol, procedure or guideline upon which the Denial was based or a statement that explains the Claimant's right to receive a copy of such information free of charge upon request; and

(6) if the denial was based on Medical Necessity or other similar exclusion or limit, the notice shall contain either:

(A) an explanation of the clinical or scientific judgment for making such decision, applying the terms of the plan to the Claimant's medical condition; or

(B) a statement that an explanation is available free of charge upon request.

If the Denial involves a Disability Claim, in addition to the above, the notification will describe any applicable contractual limitations period that applies to the Claimant's right to bring legal action. The notice will also include:

(A) Discussion of the decision, including an explanation of the basis for disagreeing with or not: (i) the views presented by the Claimant to the Plan of health care professionals treating Claimant and vocational professionals who evaluated the Claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination; and (iii) the Social Security Administration disability determination presented by the claimant to the Plan, if any.

(B) In the event no rule, protocol, procedure, or standard under section C.5(c)(5) exists, the Plan will provide a statement notifying the Claimant of the lack of existence.

C.6 External Review

The Plan will arrange for the external review of any Denial of a PPO Claim on final appeal if requested by the Claimant within four months of the decision on final appeal.

C.7 Action for Recovery

No Covered Individual may commence a lawsuit to obtain Plan benefits under a claim subject to these procedures until these claim procedures have been exhausted. These claim procedures will be exhausted when (i) the Covered Individual has submitted a claim under

these procedures and a final decision on appeal has been provided or (ii) the applicable time frame described above has elapsed since the Covered Individual filed an appeal and no final decision (or notice that an extension will be necessary) has been provided. No lawsuit may be commenced more than two years after the end of the year in which these procedures were exhausted.

APPENDIX D

Blue Shield Out-of-Area Services

Overview

The Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Plans Licensees Generally these relationships are called Inter-Plan Arrangements and they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive Services outside of California, the claims for these services may be processed through one of these Inter-Plan Arrangements described below.

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U. S. Virgin Islands (BlueCard® Service Area), you will receive the care from one of two kinds of providers. Participating providers contract with the local Blue Cross and/or Blue Shield. Licensee in that other geographic area (Host Blue). Non-participating providers don't contract with the Host Blue. The Administrator's payment practices for both kinds of providers are described below.

Inter-Plan Arrangements

Emergency Services

Members who experience an Emergency Medical Condition while traveling outside of California should seek immediate care from the nearest Hospital. The Benefits of this plan will be provided anywhere in the world for treatment of an Emergency Medical Condition.

BlueCard Program

Under the BlueCard® Program, benefits will be provided for Covered Services received outside of California, but within the BlueCard Service Area (the United States, Puerto Rico, and U.S. Virgin Islands). When you receive Covered Services within the geographic area served by a Host Blue, the San Francisco Electrical Workers Health & Welfare Plan ("Plan") will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

The BlueCard Program enables you to obtain Covered Services outside of California, as defined, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copayment, Coinsurance and Deductible amounts, if any, as stated in this SPD.

The Plan calculates the Member's share of cost either as a percentage of the Allowable Amount or a dollar Copayment, as defined in this booklet. Whenever you receive Covered Services outside of California, within the BlueCard Service Area, and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copayment, is calculated based on the lower of:

1) The billed charges for Covered Services; or

2) The negotiated price that the Host Blue makes available to the Plan.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted above. However, such adjustments will not affect the price the Plan used for your claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

To find participating BlueCard providers you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at www.bcbs.com and select "Find a Doctor".

Prior authorization may be required for non-emergency services. To receive prior authorization from the Plan, the out-of-area provider should call the customer service number noted on the back of your identification card.

Non-participating Providers Outside of California

When Covered Services are provided outside of California and within the BlueCard Service Area by non-participating providers, the amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment, the Allowable Amount the Plan pays a Non-Participating Provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment the Plan will make for Covered Services as set forth in this paragraph.

If you do not see a participating provider through the BlueCard Program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to the Plan for reimbursement. The Plan will review your claim and notify you of its coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a non-participating provider.

Federal or state law, as applicable, will govern payments for out-of-network Emergency Services. The Plan pays claims for covered Emergency Services based on the Allowable Amount as defined in this SPD.

Prior authorization is not required for Emergency Services. In an emergency, go directly to the nearest hospital. Please notify the Plan of your emergency admission within 24 hours or as soon as it is reasonably possible following medical stabilization.

Blue Shield Global® Core

Care for Covered Urgent and Emergency Services Outside the BlueCard Service Area

If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available within the BlueCard Service Area in certain ways. For instance, although Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard Service Area, you will typically have to pay the provider and submit the claim yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard Service Area you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core".

Submitting a Blue Shield Global Core Claim

When you pay directly for services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global Core claim form and send the claim form along with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Customer Service, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Special Cases: Value-Based Programs

Claims Administrator Value-Based Programs

You may have access to Covered Services from providers that participate in a Value-Based Program. Claims Administrator Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient Centered Medical Homes and Shared Savings arrangements.

BlueCard® Program

If you receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Shield through average pricing or fee schedule adjustments.

APPENDIX E
San Francisco Electrical Workers Health & Welfare Plan
Names and Addresses of Members of Board of Trustees

John Doherty IBEW Local Union #6 55 Fillmore St. San Francisco, CA 94117	Thomas Coleman SFECA 555 Gough St. San Francisco, CA 94102
Russell Au Yeung IBEW Local Union #6 55 Fillmore St. San Francisco, CA 94117	Leonard Lynch c/o SFECA 555 Gough St. San Francisco, CA 94102
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