SAN FRANCISCO
ELECTRICAL WORKERS
HEALTH & WELFARE
TRUST

SUMMARY PLAN DESCRIPTION
and
PLAN DOCUMENT

EFFECTIVE DATE: January 1, 2007

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

January 2007

DEAR PARTICIPANT:

The Board of Trustees of the San Francisco Electrical Workers Health & Welfare Trust ("the Plan") is pleased to present this restated Summary Plan Description ("SPD"). This Plan was established for you as a result of Collective Bargaining Agreements between the International Brotherhood of Electrical Workers ("IBEW") Local 6 and the San Francisco Electrical Contractors Association, Inc.

Please read this booklet carefully. In addition to summarizing the benefits to which you may be entitled, including hospital, medical, dental, vision, prescription drug and group life insurance, and related benefits, it describes the requirements for Plan eligibility, claims and appeals procedures, and other important Plan information. This booklet is both the Plan Document and the SPD.

The information in this booklet is subject to, and in no way modifies or interprets, the provisions of the policies of insurance and contracts between the Plan and the insurance carriers or providers of care. Supplemental booklets describing the benefits and services provided under each Health Maintenance Organization ("HMO") or supplemental benefit program offered through the Plan are available without cost from the Plan Office upon request. The supplemental booklets, which are incorporated by reference herein, describe the benefits provided, any additional requirements other than Plan eligibility that must be met to qualify for those benefits, whether dependent coverage is provided, information about claims and review procedures, and other matters.

It is your obligation to keep the Plan Office informed of any address change, change in a beneficiary, if you get married, register for domestic partnership, or get divorced or terminate your domestic partnership, the death of a Dependent and to provide any other requested information pertinent to the administration of the Plan. Failure to provide accurate information may result in the denial of benefits and/or loss of eligibility. **In addition, because loss of eligibility may result if any required co-payments are not timely received by the Plan, it is essential that you understand the rules for making monthly co-payments**.

The Plan is administered by the Board of Trustees subject to the terms of the Agreement and Declaration of Trust for the San Francisco Electrical Workers Health and Welfare Trust. **The Trustees have the authority and discretion to interpret, construe and apply the terms of the**

Plan and to decide all issues of eligibility to participate in the Plan, qualification for benefits under the Plan, the amount of benefits (if any) that may have become payable, and any and all other issues arising under the Plan. To assist you in obtaining your Plan benefits, the Trustees have agreed with a separate entity, the Electrical Industry Service Bureau ("EISB"), that EISB will administer the Plan.

As a courtesy to you, EISB may respond informally to oral questions; **however, oral information and answers are not binding upon the Board of Trustees or the Plan and cannot be relied on in any dispute concerning your benefits.**

Plan rules and benefits may change from time to time. Your benefits under the Plan are not vested. The Board of Trustees may reduce or eliminate or change any benefits provided under the Plan (or under any insurance policy, HMO or other entity) at any time. Participants may also be required to make new or additional contributions for benefits provided by the Plan.

If you are about to retire, Medicare benefits are not automatic; you must apply for them in order to be covered. Medicare Part A is free of charge and provides hospital benefits; Part B provides supplemental medical insurance and you are charged a monthly premium. This Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A and Part B. This means you must enroll in Medicare, for both Part A and Part B, as soon as you are eligible for Medicare. **If you do not enroll in Medicare Part A and Part B, the Plan will not cover the portion of the expense that Medicare would have paid. You must notify the Plan Office immediately upon becoming eligible for Medicare.**

Board of Trustees

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WARNING

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENT

This booklet provides a brief, general summary of the Plan rules and is also the Plan Document. You should review the Plan to fully determine your rights.

You are not entitled to rely upon oral statements of employees of the Plan Office, the EISB, a Trustee, a Union officer, or any other person or entity. As a courtesy to you, the Plan Office or EISB may respond orally to questions; however, oral information and answers are not binding upon the Plan and cannot be relied upon in any dispute concerning your benefits.

If you wish an interpretation of any provision of the Plan, you should address your request in writing to the Board of Trustees at the Plan Office. **To make their decision, the Trustees must be furnished with full and accurate information concerning your situation**.

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

SECTION I: ESTABLISHMENT AND OPERATION OF THE PLAN

A. ESTABLISHMENT OF PLAN

1. **Restatement of Plan.** The Board of Trustees of the San Francisco Electrical Workers Health and Welfare Trust restates the San Francisco Electrical Workers Health and Welfare Plan by this Plan Document effective as of October 1, 2005. The Plan's medical benefits are offered through PacifiCare of California ("PacifiCare"), Kaiser Health Plan, Inc. ("Kaiser") and the self-funded portion of the Plan.

As part of the self-funded portion of the Plan, known as the "Indemnity Plan," the Plan has contracted with First Health Group Corp. ("First Health") for access to their Preferred Provider Organization ("PPO") Network of providers that offers discounted service and for case management (special situations). The Indemnity Plan has a contract with RxAmerica to provide prescription drugs. The PacifiCare Behavioral Health Insurance ("PBHI") organization provides mental health benefits for both the Indemnity Plan and PacifiCare Participants. PBHI provides substance abuse benefits for all Participants, including members of Kaiser and PacifiCare. You should refer to the booklets for Kaiser and PacifiCare for questions on coverage and benefits from those Plans. The Plan provides certain other benefits as set forth on pages 52-59. The Plan offers dental benefits through the Delta Dental Plan ("Delta Dental") and vision care benefits through the Vision Service Plan ("VSP").

The Plan is intended to be maintained for the exclusive benefit of Employees and their beneficiaries. It is also intended that this Plan Document shall conform to the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

2. **Election of Health Maintenance Organization Benefits.** The Board of Trustees may from time to time offer to Participants the option to elect enrollment in a Health Maintenance Organizations ("HMO"). Currently, the Plan offers HMO benefits through Kaiser and PacifiCare.

An HMO uses a group of Physicians and other health care professionals (also called "network providers") who emphasize preventive care and early intervention. HMO services are prepaid--there is no annual deductible and a set premium covers services. You do share costs, however, by paying a fee called a co-payment for some services and products.

To be eligible to enroll in an HMO, you must live within the HMO's service area. In order for medical services to be covered, you must follow the HMO procedures and you must use an HMO network provider. You are required to include a street address (rather than a P.O. Box) when you enroll. If you move out of the geographic area of the HMO, you will be required to change your coverage under the Plan.

3. **Incorporation of HMO Contracts as Part of Plan.** At any time or times that the Board of Trustees enters into a new or different contract and/or renewal contract with an HMO, such contract(s) shall be incorporated in this Plan by reference as if fully set forth herein, effective as of

the date of such contract, provided that such contract has been executed by the Board of Trustees or a duly authorized representative of the Board of Trustees.

4. **Consequences of Election of HMO Plan by Participant.**

(a) Benefits Not Part of HMO. Benefits payable to a Participant and/or Dependent(s) who has elected enrollment in an HMO shall be determined solely in accordance with the contract between the Board of Trustees and the HMO.

(b) HMO Rules Apply. In addition, any rules or regulations set forth herein regarding but not limited to claims review and/or appeals shall be governed by the rules and regulations of the HMO without regard to similar rules and regulations that may be otherwise set forth in this Plan. For example, the terms set forth in Section IX "Claims Filing and Appeal Procedures", starting on page 65, are not applicable to claims for benefits provided by Kaiser and/or PacifiCare.

B. PLAN MAY BE CHANGED

The Board of Trustees expressly reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time. In addition, future amendments to the Plan may be made from time to time to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Trustees.

For example, the Board of Trustees expressly reserves the right, in its sole discretion, to:

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

The authority to make any such changes to the Plan rests solely with the Board of Trustees. Any such amendment, modification, revocation or termination of the Plan shall be made by a resolution adopted by the Board of Trustees. No individual Trustee, Union representative, or Employer representative is authorized to interpret this Plan on behalf of the Board of Trustees, or to act as an agent of the Board of Trustees.

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.

C. ADMINISTRATION AND OPERATION

1. **Board of Trustees Responsibilities.** The Plan is administered by a Board of Trustees consisting of six Trustees and two Alternate Trustees. One-half of the Trustees, called "Employer Trustees," are selected by the San Francisco Electrical Contractors Association Inc. ("SFECA"), which is signatory to the IBEW Local 6/SFECA Inside Wireman Collective Bargaining Agreement. The other half of the Trustees, who are called "Union Trustees", are selected by IBEW Local 6. The current Trustees are listed on page 78 of this booklet. The Trust Agreement permits Alternate Trustees to attend all meetings and take action only when a regular Trustee is not available.

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

The Plan is administered through the EISB having its office at:

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

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

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

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

3. **Delegation of Duties and Responsibilities.** The Board of Trustees may engage such employees, accountants, actuaries, consultants, investment managers, attorneys and other professionals or other persons to render advice and/or to perform services with regard to any of its

responsibilities under the Plan, as it shall determine to be necessary or appropriate.

4. **Employer Contributions.** Employer contributions are made to the Plan pursuant to the terms of a recognized collective bargaining agreement as defined in the Trust Agreement or a Letter of Assent to such collective bargaining agreement ("Collective Bargaining Agreement"). Contribution rates for each hour of Covered Employment are set, from time to time, by the parties to the Collective Bargaining Agreements. Your Employer is required to contribute only for such hours of work that are required by the Collective Bargaining Agreement.

Your Employer is required to make monthly contributions for your Covered Employment by the dates specified in the joint services agreement pursuant to the delegation by the Plan to EISB. By way of example, January hours generate employer contributions in February which are posted on the Plan's books when received, but are not credited to employees until March. Each monthly payment made by your Employer is accompanied by a transmittal form that contains the names, Social Security numbers, and hours of work performed by each Covered Employee together with a payment to the Plan. The Employer contributions to the Plan are not subject to withholding for Federal Insurance Contribution Act ("FICA"), Federal Unemployment Tax Act ("FUTA"), or state or federal taxes. (See Section XIV, *Definitions* for Covered Employee, Covered Employment and Employer.)

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 which requires correction.

ALERT:

IF YOU BELIEVE YOUR EMPLOYER IS NOT CONTRIBUTING FULL AMOUNTS

Notify the Union and the Plan Office immediately if you are aware or suspect that your Employer has not contributed to the Plan on your behalf the full amount required under your Collective Bargaining Agreement.

The amount of Employer contributions made to the Plan for non-bargaining unit employees (such as employees of the Union, the Joint Apprentice and Training Committee ("JATC") and others not working under a Collective Bargaining Agreement) will be governed by individual subscription agreements entered into with the Plan and any rules adopted by the Board of Trustees.

5. **Loss of Eligibility if No Contributions.** Eligibility is not credited unless the Employer contributions are received by the Plan Office. The only exception is that if you lose eligibility because of the Employer contribution delinquency (and have no hours left in your hour bank), eligibility is granted for up to two months.

6. **Availability of Plan Resources.** Benefits provided through this Plan can be paid only to the extent that the Plan has adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder, beyond the obligation to make contributions as provided in the Collective Bargaining Agreement. In the event that at any time the Plan does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any Contributing Employer to make benefit payments or contributions (other than the contributions for which the Contributing Employer may be obligated by the Collective Bargaining Agreement) in order to provide for the benefits established hereunder. (See Section XIV, *Definitions*, for Employer/Contributing Employer.)

There shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, the Union, signatory associations or other person or entity to provide benefits established hereunder if the Plan does not have sufficient assets to make such benefit payments.

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

8. **Special Exclusion for Fraud.** No benefits will be paid for fraudulent claims of service or supplies by a Participant, Dependent, or any other person. If a fraudulent claim has been paid on behalf of any person, both you, the Participant and any person on whose behalf a fraudulent claim was submitted as your Dependent will be liable to the Plan for repayment of any benefits paid on your behalf or on behalf of your Dependent against the amount which was fraudulently paid on behalf of yourself or the other person.

If you or your Dependent has any outstanding liability for fraudulently paid claims, neither you nor your Dependents may assign any rights to benefits to a provider of services or supplies until all fraudulently paid benefits are repaid in full. If fraudulently paid benefits are not repaid in full, any purported assignment of benefits by you or your Dependent may be disregarded by the Plan, and payments 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 fraudulent claims have not been repaid when you or your Dependent incurs Covered Charges, you or your Dependent shall pay all charges directly and file a claim for credit in lieu of benefits, until the entire amount of the fraudulent claims have been credited.

D. YOUR RESPONSIBILITIES

1. **Your Mailing Address.** Be sure to keep the Plan Office advised of changes in your address. Even if you leave the electrical industry or your Local Union you may continue to receive Plan information regarding your potential entitlement to benefits in the future.

2. **Enrollment Form.** You should keep your enrollment form updated by adding

new spouse, Domestic Partner or children with required proof, such as a marriage or Domestic Partner registration certificate, birth certificate and/or legal adoption papers). You are required to notify the Plan Office if a Dependent no longer meets the Plan's requirements (e.g., divorce, death and over-age dependents).

3. **Beneficiary Form.** You should complete a beneficiary form for the payment of the Plan's death benefit (currently $1,000), and keep it current so that family members or others that you wish to receive your benefits receive them without delay. If you are married, benefits are automatically paid to your legal spouse *unless* he or she consents in writing before a notary. You should consider submitting a new form if there is a major change in your life circumstance (such as a marriage or divorce).

4. **Privacy Protected Health Information.** The Board of Trustees has adopted certain privacy rules and forms in accordance with the Health Insurance Portability Accountability Act of 1996 ("HIPAA"). If you wish to authorize someone other than yourself to access information, you must complete the *Authorization Form* (which is available at the Plan Office) and return it to the Plan Office.

SECTION II: ELIGIBILITY FOR BENEFITS

A. ACTIVE MEMBER ELIGIBILITY RULES

1. **"Active" Member Defined.** Individuals who are members in good standing in IBEW Local 6 as required by a Union security agreement with a Contributing Employer, or who are otherwise eligible to participate in or to maintain Plan participation by law, are Active members of the Plan provided that the eligibility requirements set forth in paragraphs 2-6 below are followed.

Individuals employed with IBEW Local 6, the EISB, and the San Francisco Electrical Workers Apprenticeship Trust are also eligible to participate in the Plan subject to rules in a signed subscription agreement.

2. **Hour Bank Reserve Account System.**

(a) Hour Bank Reserve - Hours Credited. A reserve account system will be maintained by the Plan Office. The account will include a separate record for each Active member and will show the member's accumulation of hours worked reported from each Contributing Employer to the Plan or reciprocated to the Plan pursuant to the Electrical Industry Health and Welfare Reciprocal Agreement ("Reciprocal Agreement") described in paragraph 5 below, beginning on page 8, and subject to subparagraph c, below. Hours that are not used to provide eligibility are credited toward your hour bank reserve. You may build up your hour bank reserve to a maximum of 1,000 hours and shall have no claim for hours or contributions reported in excess of 1,000 hours. Moreover, the Board of Trustees may reduce, extend or terminate your reserve hour bank at any time. There is no guaranteed or vested right to such hours.

(b) Loss of Hour Bank Reserve Hours. If you have not had eligibility under the Plan for a period of twelve consecutive months or more, any and all hour bank reserve hours will be canceled. Should you thereafter return to Covered Employment, you will be required to reestablish eligibility as provided for in paragraph 3 below.

You will lose all of your hour bank reserves and will not be entitled to further coverage under the Plan if you:

(i) continue to be employed by an Employer who ceases contributions to the Plan pursuant to the termination of such Employer's Collective Bargaining Agreement; or

(ii) become employed by an employer in the same industry as any Employer that contributes to the Plan and your employer is not a Contributing Employer to the Plan or any IBEW-sponsored health plan.

(c) Pro-rating Eligibility Credit. Effective January 1, 2006, if your Employer

is a Contributing Employer to the Plan but whose contribution rate is different from the Inside Wire contribution rate, your eligibility credit under subparagraph a, above, will be prorated based on the relationship of your Employer's contribution rate and the Inside Wire contribution rate after being adjusted for the difference in the work week or benefit level.

3. **Initial Coverage.** In order to qualify for initial coverage under the Plan, you must have accumulated an hour bank reserve credit of a minimum total of 300 hours of Covered Employment within a continuous twelve-month period for which contributions have been made pursuant to the terms of a recognized Collective Bargaining Agreement. **Coverage is to be effective on the first day of the second month following the month in which the 300 hour requirement is met**. As an example, if you begin working in January and accumulate 300 hours by the end of March, your coverage will become effective May 1st.

4. **Continued Coverage.** Currently the charge for coverage is 120 hours per month against your accumulated hours until insufficient hours remain in your hour bank reserve. Prior to January 2007, the charge for coverage was 125 hours. The amount of this charge may be changed at any time by the Board of Trustees. Hours worked in one month shall not apply toward coverage in the next month, but in the second following month. In other words, your eligibility will continue for as long as your reserve hour bank contains at least 120 hours. The 120 hours can come from one of the following sources:

(a) contributions made on your behalf by a Contributing Employer; or
(b) from hour bank reserves; or,
(c) if you are eligible, under the self-pay or temporary disability provisions set forth in III.A, or III.B, beginning on page 21.

Requisite hours cannot be made up of a combination of self-pay and hours worked; or of self-pay and hour bank reserves. Exception: Apprentices in good standing who are attending day classes, may, in such an event, count day class hours actually attended up to the number of hours required to maintain eligibility or the number of hours attended in day classes in a particular month, whichever is less. Class hours may not be carried over from month to month to maintain eligibility.

5. **Industry Reciprocity.** In order to re-establish or preserve continuity of coverage in this Plan, you may apply to have contributions made on your hours worked transferred from a "Reciprocal Fund" (a health and welfare plan sponsored by a Local Union of the IBEW and chapter of NECA) in accordance with the Reciprocal Agreement. To qualify, this Plan must be your "Home Fund" (the health and welfare plan to which contributions will be transferred and through which your health and welfare benefits will be covered), you must register on ERTS (the Electronic Reciprocal Transfer System), and you must present a valid photo identification at your Home Fund, the Participating Fund in which you have registered for work or an Assisting IBEW Local Union. You must agree both in writing and electronically (via ERTS) to (1) the legally binding effect of utilizing an electronic signature on ERTS and (2) an approved authorization and release regarding reciprocal transfers under the Reciprocal Agreement.

You may designate this Plan as your Home Fund if you are a member of IBEW Local 6 and have been eligible for benefits under this Plan at any time during the past six years. You may designate this Plan as your Home Fund if you are a member of another IBEW Local Union that is party to the Reciprocal Agreement if:

(a) you are currently eligible for benefits under this Plan,

(b) you have not been eligible for benefits under your Local Union's Health and Welfare Plan at any time during the past six years, and

(c) you establish your intent to return to work under the jurisdiction of this Plan as soon as work is available.

The effective date of the transfer is the first day of the month in which you have properly registered on ERTS, provided you meet the eligibility requirements to claim the Plan as your Home Fund as described above. Upon approval of the application based on the foregoing rules, the lesser of (l) contributions in an amount provided in the current Collective Bargaining Agreement of the Plan, or (2) contributions in an amount provided in the current Collective Bargaining Agreement of the Participating Fund in which you are working, will be transferred. If the contribution rate in this Plan is greater than that in the remitting Participating Fund, the Plan Office shall, on behalf of the Plan, prorate the hours reported based on relationship the Participating Fund rate bears to this Plan's rate.

Reciprocity under this paragraph 5 will remain in effect unless, and until, you complete a "Request for Cessation of Transfer" on ERTS. For further information regarding the procedure, please contact the Plan Office.

The terms of the Reciprocal Agreement may be changed or amended from time to time by vote of the participating trusts throughout the United States. To determine whether changes have occurred in the Reciprocal Agreement since the printing of this booklet, contact the Plan Office.

B. RETIREE MEMBER ELIGIBILITY RULES

1. **Retiree Defined.** A member in good standing of the IBEW who retires from the electrical industry and who can meet the requirements set forth below will qualify for enrollment as a Retiree member.

2. **Regular Retirees.** If you have attained at least age 62, you will qualify for enrollment as a Regular Retiree if you have satisfied one of the following requirements:

(a) 120-Month Option. You have been covered as an Active member for 120 out of the last 180 months and two (2) periods of 12 consecutive months

within the 60 months immediately preceding age 62 or subsequent retirement age.

(b) 300-Month Option/Retired.

(i) you have been covered as an Active member for at least 300 months of which at least two (2) periods of 12 consecutive months of coverage were within the 60 months immediately preceding age 62 or subsequent retirement age; and

(ii) you qualify for retirement and have retired under the Northern California Electrical Workers Pension Plan ("NCEW Pension Plan").

(c) 150 Month Option/Retired.

(i) you have been covered as an Active member for at least 150 months out of the last 240 months of which at least two (2) periods of 12 consecutive months of coverage were within 60 months immediately preceding age 62 or subsequent retirement age; and

(ii) you qualify for and have retired under the Northern California Electrical Workers Pension Plan.

(d) Continuous Coverage Since Inception/Enrolled Apprentice.

(i) you have been continuously covered as an Active member since the inception date of your work in the electrical industry; or

(ii) you are currently an enrolled apprentice in a San Francisco Electrical Industry Apprenticeship program.

NOTE: Participation as an Active member includes participation in the Electrical Workers Area Health and Welfare Plan, the predecessor to this Plan which terminated February 1, 1998. A Retiree's "Home Plan" is the successor Plan to the Area Retiree Health & Welfare Plan, sponsored by the Local Union and NECA chapter in whose jurisdiction the majority of Active member contributions were made on his or her behalf. For example, if a Retiree has ten (10) years of participation as an Active member, but only four (4) of those were through the IBEW Local 595 Trust and six (6) were through the IBEW Local 6 Trust, Retiree coverage will be provided by the Local 6 Trust, not the Local 595 Trust. This rule applies to IBEW Locals 639, 595 and 6 only.

3. **Disability Retirees.** If you are a Covered Employee under age 62 and become totally and permanently disabled, as defined in subparagraph c, below, while Active coverage is

in force, you will qualify for enrollment as a Disabled Retiree member provided:

(a) you have exhausted coverage pursuant to your hour bank reserve and/or temporary disability coverage; and

(b) you have been covered as an Active member for 120 out of the last 180 months and two (2) periods of 12 consecutive months within the 60 months immediately preceding the date of onset of disability; and

(c) proof of total and permanent disability is submitted.

"Total and permanent disability" means that the applicant is unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment which 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 the individual not only from engaging in the individual's usual work but, considering the individual's age, education, previous training and work experience, from engaging in any substantial gainful work which exists in significant numbers in the region in which the individual lives.

You must be under the care of a legally qualified 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 deems you to still be totally and permanently disabled will be required at reasonable intervals by the Plan.

A Social Security disability award will be presumptive proof that you are permanently and totally disabled; however, that presumption may be rebutted by other pertinent evidence. If you fail to furnish proof, or if you refuse to be examined by a Physician (designated and paid for by the Plan), you will no longer be considered totally and permanently disabled for purposes of disability retirement eligibility under the Plan.

4. **Early Retirees.** Subject to the following provisions, if you retire, you may maintain coverage in the Plan as an Early Retiree.

(a) Minimum Age Requirement. You must be at least 55 years old.

(b) Retirement Requirement. You must have retired under the Northern California Electrical Workers Pension Plan. **Exception:** Participants of the Plan who work under IBEW Local 6 Collective Bargaining Agreements that do not require contributions to the NCEW Pension Plan (e.g., employees working under the Storekeeper and Residential Wire Agreements) are exempt from this requirement, provided that based on their hours worked, they would have otherwise qualified under the service requirements under the NCEW Pension Plan.

(c) Service Requirements. You must satisfy one of the four Regular Retiree service requirements as set forth in paragraph 2, above, at your retirement date to qualify as an

Early Retiree between ages 55 and 62.

If you satisfy the service requirements in paragraph 2 within the period immediately preceding age 62 or subsequent age, (which, among other things, requires that your hour bank runs out after you attain age 59) you will not to be required to continue Early Retiree participation and pay the Early Retiree copayments in order to participate as a Regular Retiree. However, if at the exhaustion of your hour bank you elect not to enroll as an Early Retiree, you may not again participate until you are eligible as a Regular Retiree at age 62.

If you do not satisfy the service requirements in paragraph 2 within the requisite periods immediately preceding age 62 or subsequent age, (generally, your hour bank runs out before you attain age 59), you **will be required** to participate as an Early Retiree and pay the monthly co-payments in order to participate as a Regular Retiree at age 62.

The current Early Retiree and Regular Retiree Co-payment Schedules are included in Appendix 1. Generally, these amounts are adjusted annually on August 1st based on percentage increases to the Plan following contract renewals with the various Plan carriers. Since the copayment amount required between ages 62 and 65 varies depending upon whether or not you satisfy the service requirements in the period prior to age 62, you may want to review the copayment schedule, or contact the Plan Office, before making your retirement plans.

(d) Self-Payment Periods Not Counted. Periods of Early Retiree self-payments and COBRA self-payments are not taken into account to determine Retiree status at age 62 or 65. (See Section IV describing COBRA Extension Coverage.) Early Retirees must meet the requirements for Regular Retiree member status by satisfying the requirements set forth in paragraph 2, above, solely from periods of coverage as an Active member. This includes periods of direct self-payments (during periods of unemployment) and periods of temporary disability coverage.

5. **Effective Date of Retiree Coverage.**

(a) Regular or Disability Retiree Coverage. If you meet all of the requirements to qualify for Regular or Disability Retiree coverage under the Plan, you will become eligible for Retiree coverage effective on the first of the month following submission of a completed application for enrollment or upon exhaustion of any temporary disability coverage or hour bank reserve, whichever occurs later. **Exception:** A maximum of 12 months of retroactive coverage will be credited to a Disabled Retiree who submits his or her application within 60 days from the date of receipt of a *Social Security Disability Award Notice*.

(b) Early Retiree Coverage. Early Retiree coverage must commence with the later of:

(i) the first of the month following termination of coverage based on Employer contributions and exhaustion of the member's reserve hour bank (including temporary disability coverage) or

(ii) the first of the month following retirement under the Northern California Electrical Workers Pension Plan. An application for Early Retiree coverage received by the Plan Office more than 60 days following the later of retirement or exhaustion of hour bank reserve coverage shall be deemed "untimely" for the purposes of this subparagraph.

If you are an Early Retiree who is eligible to defer Retiree coverage pursuant to paragraph 4(c)(i)(I), above, you shall be deemed to have chosen to defer enrollment when an application for Early Retiree enrollment is not received by the Plan office within 60 days of the last qualifying date for entitlement to Early Retiree coverage.

Early Retiree self-payments are due by the **10th of the month** preceding the month for which coverage is to be provided. Failure to make timely payments may result in the cancellation of Early Retiree coverage without a right of reinstatement. At your request, your Retiree health care premiums may be deducted from your monthly pension benefit from the Northern California Electrical Workers Pension Plan. A form permitting the deduction from your pension check is available from the Plan Office.

(c) Retiree Dependent Coverage. Coverage for your Dependents as defined in subsection C, below, will become effective on the later of the following dates:

(i) the date you become eligible for Retiree coverage; or

(ii) the first of the month after you acquire a Dependent, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

6. **Monthly Charge for Retiree Coverage.** The Plan may charge Retirees and surviving spouses and other Dependents a monthly charge for coverage. The Board of Trustees has the discretion to change at any time the amount of the monthly charge based on the cost of coverage to the Plan. Co-payments are subject to a formula determined by the Board of Trustees and based on the Plan's benefit consultant's calculations. The rates may differ between different categories of Retirees.

7. **Medicare Enrollment.** Medicare is our country's health insurance program for people age 65 or older, certain people with disabilities who are under age 65, and people of any ages who have permanent kidney failure. If you are receiving Social Security Disability Income ("SSDI") benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin.

There are two parts to Medicare that relate to hospital and medical insurance. They are hospital insurance (Medicare Part A) and medical insurance such as for the cost of Physicians (Medicare

Part B). Medicare Part A is financed by payroll taxes; and, if you are eligible to receive it based on your own--or your spouse's--employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by those who choose to enroll. For enrollment and eligibility information, call Social Security at 1-800-772-1213. You can also find Medicare information on the Internet at www.medicare.gov.

The Plan offsets expenses for services or supplies to the extent they are or may be payable under Medicare. For this purpose, if you are a Medicare-eligible Retiree, the Plan Office will assume that you have full Medicare coverage (Parts A and B) whether or not you have enrolled for the full coverage. Therefore, if you are a Retiree who has selected coverage under the Indemnity Plan, once you or your Dependent becomes eligible to enroll in Medicare, the Plan will process any claim for Covered Expense incurred on or after that date as though it is secondary to Medicare coverage, even if you or your Dependent fails to enroll. If you or your Dependent is eligible to enroll in Medicare and has selected one of the Plan's HMOs, you or your Dependent must enroll in the HMO's Medicare Program ("Medicare Part C"). The difference between the premiums charged to the Plan and the premium for the Medicare Program will be billed back to you as the Retiree member if you and/or your Dependent fail to enroll in the Medicare Risk Program. If you or your Dependent does not reside in the HMO's Medicare service area, you must enroll in one of the other available plans.

Medicare Part D is addressed in VII.A, beginning on page 52 of this booklet.

8. **Suspension/Cancellation of Retiree Benefits.**

(a) General Rule. If you are eligible for benefits as a Retiree member, you shall have such eligibility suspended during any period you have returned to work in "prohibited employment" as either defined below or which would result in a suspension of benefits under the NCEW Pension Plan:

(i) Prior to Age 65. Before the attainment of Normal Retirement Age (65), "prohibited employment" means the performance of services in any capacity in the electrical industry in the United States.

(ii) After Attainment of Age 65. After attainment of Normal Retirement Age "prohibited employment" means the performance of services of 40 hours or more during the month:

(I) in the ten counties comprising the San Francisco Bay Area: San Francisco, Alameda, San Mateo, Contra Costa, Marin, Solano, Napa, Santa Clara, Sonoma and San Benito;

(II) of the type performed by Employees covered by the NCEW Pension Plan on your Pension Effective Date; and

(III) which requires directly or indirectly the use of the same skills

employed by Employees on the Pensioner's Pension Effective Date, including any supervision of employees in the same trade or craft or directly or indirectly using the same skills as Employees covered by the NCEW Pension Plan on the date the Pensioner retired.

"Prohibited employment" and "work" includes employment for which a salary is paid, work as an independent contractor, work for which the NCEW Pension Plan Participant receives a deferred benefit and work for which the NCEW Pension Plan Participant receives anything of value in exchange for services rendered.

(b) Exceptions to the Suspension of Benefits Rule. The NCEW Pension Plan provides a limited number of exceptions that allow a Retiree to engage in otherwise prohibited employment. Those exceptions are:

(i) as a private or public building or electrical inspector;

(ii) as an instructor in a Taft-Hartley Trust apprenticeship and training program;

(iii) in sales of electrical equipment or products; or

(iv) in the manufacturing or marketing of electrical or electronic products and systems which does not substitute for on-site fabrication that is protected or which is sought to be protected under IBEW Inside Wire Agreements.

(c) Retiree Coverage Continued for Limited Time. If you are receiving Retiree benefits under this Plan and return to Active employment pursuant to a Collective Bargaining Agreement requiring contributions on your behalf to establish eligibility for coverage under the Plan, your Retiree benefits shall be suspended commencing upon the date your eligibility as an Active member is reestablished or upon the first of the third month following the date of your return to Covered Employment, whichever occurs first.

(d) Reinstatement Rule. Upon notification that your pension benefits are no longer suspended, Retiree benefits shall be reinstated no later than the first of the third month following the last month for which benefits were suspended.

(e) Forfeiture Rule. If you are an Early Retiree (including an Early Retiree who elects to defer Retiree coverage under the Plan), you must refrain from engaging in work in the electrical industry unless you return to work for a Contributing Employer. **If you return to work for a non-Contributing Employer, your coverage or eligibility for deferred coverage under this Plan will be canceled without right to reinstatement and you will be obligated to reimburse the Plan for any benefits paid on your or your family's behalf during any period of such**

employment.

If you are an Early Retiree who returns to employment covered under the Plan and who subsequently becomes eligible for coverage as an Active member based on your work hours, you will not be required to continue making Early Retiree self-payments. Upon subsequent retirement prior to age 62, you will be required to make continuous early retirement self-payments until you qualify for full Retiree status.

9. **Annual Verification of Retiree and/or Dependent Eligibility.** In order for you or your Dependent to maintain eligibility for Retiree benefits under this Plan, you must submit a completed *Verification of Eligibility* form must be returned to the Plan Office at least once a year. This form will be sent to Retirees at a time designated by the Board of Trustees.

C. DEPENDENT ELIGIBILITY RULES

1. **Dependent Defined.** "Dependent" means your lawful spouse, your Domestic Partner as defined below, an unmarried dependent child under 19 years of age, and your unmarried child who has attained age 19 but who has not reached his or her 25th birthday if he or she is dependent on you for support and is attending an accredited trade school, college or university as a full-time student as defined by the educational institution.

(a) **Child Defined.** "Child" includes your natural child, stepchild, legally adopted child, foster child, your Domestic Partner's child or other child provided such child is dependent upon you for support and maintenance and is part of your household, or a child for whom you have been appointed legal guardian or are required to provide dependent coverage pursuant to a Qualified Medical Child Support Order ("QMCSO"). (See paragraph 4, below, for a description of a QMCSO.)

Summer months are covered provided the Dependent was a full-time student the previous Spring semester or quarter. You are required to provide proof of full-time student status each quarter or semester, whichever is applicable.

(b) **Domestic Partner Defined.** "Domestic Partner" is defined as a spousal equivalent relationship sanctioned by the laws of a state, county, city or other municipality. Domestic Partners shall become eligible on the first day of the month following the month the Plan Office receives proof of Domestic Partner status in the form of an official certification of registration of domestic partnership and either (1) an affidavit of "dependency" for tax purposes, or (2) advance remittance of at least six months of taxes the Plan Office determines are due on the additional imputed taxable income to the member, including the employer's portion of such taxes. The Plan will not be responsible for any taxes, tax-related penalties or interest imposed on the member as a result of providing Domestic Partner coverage.

2. **Disabled Dependent Child Age 19 through 24.** Your dependent child whose coverage would otherwise terminate solely due to attainment of the limiting age may continue to

be considered a Dependent while he or she is incapable of self-sustaining employment by reason of mental or physical disability, provided written evidence of such incapacity is furnished to the Plan Office with respect to that child by the thirty-first day after the later of (a) the attainment of such age, or (b) the date you become aware of your child's incapacity. Proof of the continued existence of such incapacity must be furnished to the Plan Office from time to time at the Plan's request. The Board may require that your child see a Physician or other specialist selected by the Plan.

3. **Dependent Coverage upon Death of Member.** Upon your death, your surviving spouse and Dependents will be eligible for benefits until your hour bank reserve is exhausted. Thereafter, if you died while you were an Active member or Early Retiree, your Dependents (other than a Domestic Partner or the children of a Domestic Partner) will be eligible for Retiree coverage if, regardless of your age at the date of death, you would have met the Active member coverage requirements for Retiree membership eligibility set forth in B.2. If you died while you were a Regular Retiree, your Dependents will remain eligible for Retiree member Dependent coverage in the Plan upon your death.

In all cases, surviving spouse coverage will cease upon a remarriage. If the requirements under B.6 *Monthly Charge for Retiree Coverage*, above, are not satisfied, Dependents (other than Domestic Partners or children of Domestic Partners) are eligible for enrollment in COBRA or the standard conversion plan, if any. If you have no Dependents at the date of your death, your successors shall have no claim for coverage, payments, or refunds.

4. **Qualified Medical Child Support Order ("QMCSO").** You must provide written proof of legal dependent status such as a birth certificate for a child, a decree of adoption for an adopted child and a marriage certificate for a spouse. You must furnish the Plan Office with a copy of a court order for any child who has been appointed to your care pursuant to a court-ordered guardianship or QMCSO. A copy of the Plan's QMCSO procedures may be obtained from the Plan Office without charge. A QMCSO recognizes an eligible child's right to receive Plan benefits as a beneficiary of an eligible Plan Participant. The child, to be covered by the benefits of this Plan, must be a Dependent as defined in the Plan.

The steps that will be followed to establish and determine the qualified status of a QMCSO are:

(a) You must provide the Plan Office a copy of your QMCSO.

(b) Within thirty (30) days after receipt of the QMCSO, the Plan Office will notify you and the Dependent (through his or her custodial parent, guardian or representative), in writing, if the QMCSO is acceptable to the Plan.

(c) If the Plan determines that the Court order does not constitute a QMCSO, or additional information is required, you and the Dependent (through his or her custodial parent, guardian or representative) will be notified in

writing by the Plan or the Plan's legal counsel.

(i) If the QMCSO is denied, the notice shall describe the reasons for this decision. There is a right to appeal a denial, and the summary of the Plan's appeals procedures will be included in the notice of denial.

(ii) If additional information is required, notification will be provided as to what is needed, and you will have sixty (60) days to respond. If you do not respond within sixty (60) days, the request for the QMCSO will be deemed canceled.

You will be required to certify under penalty of perjury that the dependent child meets these requirements.

5. **Proof of Continued Dependent Status.** You are required to notify the Plan immediately if any individual ceases to be your Dependent. Proof of the continued existence of Dependent status must be furnished to the Plan Office from time to time at the Plan's request.

D. PLAN SELECTION AND ENROLLMENT

1. **Plan Selection.** Under the Plan, you may select among various benefit options, including an indemnity option or two HMO options. Refer to Section VI for general information concerning HMOs that are available under the Plan. If you do not select one of these options, you will automatically be enrolled in the Indemnity Plan. (See V.A.)

2. **Open Enrollment.** You will be given the opportunity to change Plan selections during special open enrollment periods which usually occur during the month of July, with changes effective August 1st. The Plan will send open enrollment material with Plan information shortly before each open enrollment period. Be sure to enroll your Dependents when you first enroll, otherwise, subject to Special Enrollment provisions in paragraph 3, below, you may enroll your Dependents only during open enrollment. Exception: the Plan allows enrollment when your Dependent is first eligible for coverage as a result of marriage, domestic partner registration, birth or adoption of a child, or the enrollment of a dependent child over age 19 as a full-time student. **All of your Dependents are covered in the same option that you choose for yourself, if they are properly enrolled in the Plan. No benefits are payable for any person who is not properly enrolled. The Board has the discretion to change or establish other open enrollment periods.**

3. **Special Enrollment.** If Plan benefits are available without cost to you, you will ordinarily want to enroll in the Plan, along with your spouse or Domestic Partner and other Dependents. Potentially, however, you might want to decline enrollment for an otherwise eligible family member (e.g., to avoid taxable income for covering a persons who do not meet the definition of dependent under the Internal Revenue Code). If you decline enrollment for any

eligible individual who has other health insurance coverage, you may later enroll that individual in the Plan if you request enrollment within 30 days after that other coverage ends. Also, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents if you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

4. **Optional Supplemental Benefit for Medicare-Eligible Retirees.** Medicare-eligible Retirees and/or Dependents who have chosen to enroll in a Medicare program not offered through the Plan may elect the supplemental benefit program as described in Section VII, *Supplemental Benefits*, beginning on page 52. If you are a Medicare-eligible Retiree and choose supplemental benefit coverage only, you may opt into one of the Plan's available Medicare Risk programs (e.g., PacifiCare Secure Horizon or Kaiser Senior Advantage) but only during a Plan open enrollment period.

Please note that if you are a Medicare-eligible Retiree and choose to enroll with an outside Medicare Part D provider (covering prescription drugs), you will automatically be dis-enrolled from the Plan's medical programs including the Indemnity Plan, PacifiCare Secure Horizon and Kaiser Senior Advantage, and your and your family's coverage under the Plan will be limited to the dental and vision supplemental benefits. See VII. B and C.

5. **Enrollment Cards.** If you are an Active member as defined in II.A.1, you are required to complete an enrollment card and must, in order to cover your Dependents, include copies of marriage certificates or Domestic Partner registration certificates, where appropriate, and birth certificates for yourself and for all your Dependents. Proof of full-time student status is required for all dependent children who have attained age 19. (See II.C.1 defining Dependent.)

6. **Effective Date of Eligibility.** All members and their Dependents who qualify under the Section II eligibility provisions of this booklet shall be covered effective 12:01 a.m. of the first day on which they qualify.

E. TERMINATION OF ELIGIBILITY

Your or your Dependents' coverage will terminate upon the occurrence of the first of the following events:

1. the last day of the month in which your hour bank provides the minimum required hours;

2. the date you fail to make any required self-payment under the Plan by its due date;

3. the date the Plan is modified to terminate one or more classes of eligible members, or to terminate one or more benefits;

4. the date your status as a Participant or beneficiary terminates;

5. (for Medicare-eligible Retirees) the date you enroll with a Medicare Part D provider outside this Plan;

6. the first date in which you work in non-Covered Employment in the electrical construction industry; and

7. your failure to abide by the Plan's provisions which results in forfeiture of coverage, or you fail to maintain your membership in good standing in IBEW Local 6.

SECTION III: NON-COBRA CONTINUATION OF COVERAGE

A. DIRECT SELF-PAYMENT

If you are already covered under this Plan and your accumulated credit for hours worked has fallen below 120 hours, you may, in order to maintain continuous coverage, make payments directly to the Plan under the following conditions:

1. **Amount.** The amount of such payment is to be set by the Board of Trustees. In no event may hour bank reserves of less than 120 hours be used to offset the payment required to maintain one month of coverage.

2. **No Break in Payments.** There may not be a break in payments. All payments must be **received** by the Plan Office by the 20th of the month prior to the month for which coverage is to be effective. The first such payment shall be accepted if remitted within 20 days of notice to you regarding loss of coverage.

3. **Availability for Employment; Exceptions.** To qualify for continuation of coverage by direct self-payments, you must be available for immediate employment with a Contributing Employer. There are two exceptions:

(a) Disability. If you are disabled and unable to work and present a Physician's opinion satisfactory to the Plan Office to that effect. The Plan may designate a Physician or other medical provider to make such determination; or

(b) Approved Leave of Absence. If you obtain written approval from the Board of Trustees to make direct self-payments during an extended leave of absence, subject to the time limits outlined in paragraph 4 below.

4. **Maximum Period of Direct Self-Payment Coverage.** So long as you continue to qualify for direct self-payments, such payments may continue for up to a maximum of 12 consecutive months, provided that if at any time during the 12-month period you are disabled and unable to work, and present a Physician's opinion to that effect, you may qualify for up to 12 months of temporary disability coverage as described in B.2, *Temporary Disability Coverage,* below. **In no event, however, may the combination of direct self-payment coverage and/or temporary disability coverage exceed a total of 24 months for any single disability as defined below. All periods of direct self-payments will be included for purposes of determining eligibility for Retiree coverage.**

5. **Special Apprentice Rule.** The amount required to be paid under the Plan's direct self-payment provisions shall be deemed paid if you are an apprentice attending day classes under the following terms and conditions:

(a) you have actually attended day classes for a sufficient number of hours during the affected eligibility period that, had such hours been deemed by the Plan as "work performed in Covered Employment," you would have achieved or maintained coverage under the Plan; and

(b) you are eligible under rules adopted and/or implemented by the IBEW Local 6 JATC for reimbursement of self-payments paid to the Plan on account of time actually spent in apprentice training day classes; and

(c) you actually pay to the Plan sufficient contributions, in a timely manner, to bring your number of hours, during the eligibility period, up to the minimum eligibility hours needed to maintain coverage under the Plan; and

(d) the Director of Apprentice Training certifies to the Plan Office that you are eligible for this special rule.

B. TEMPORARY DISABILITY COVERAGE

1. **Application for Coverage.** If you become temporarily disabled while Active member coverage is in force (excluding coverage through COBRA payments), you may submit to the Plan Office, in writing, evidence of such disability in the form of certification of continuing disability by your attending Physician, along with an *Application for Temporary Disability Coverage* if you meet the following requirements:

(a) you are unable to perform the duties of your regular occupation covered under an IBEW Local 6 Collective Bargaining Agreement; and

(b) your disability continues for a period of thirty (30) days.

Such application must be submitted no later than ninety (90) days from the date your hour bank reserve runs out. The Board of Trustees may designate a Physician or other medical provider to make the disability determination. The Board reserves the right to place a limit on temporary disability coverage.

2. **Coverage Period.** If your *Application for Temporary Disability Coverage* is approved, you shall, upon expiration of your hour bank reserves, if any, have your Plan coverage extended without charge while you are disabled for a period not to exceed the lesser of:

(a) 12 months; or

(b) the number of months of Active member eligibility supported by your hours worked, hour bank reserves and/or direct self-payments in the 12-month period preceding the later of:

(i) the date of the onset of disability; or

(ii) the date on which your Active member eligibility has run out.

Thereafter, you may make direct self-payments, but in no event shall the combination of temporary disability coverage and coverage resulting from the direct self-payment provision above, exceed a total of 24 months' coverage for any single disability.

3. **Limited 3-Month Extension.** Temporary disability coverage will be extended for up to 3 months following the month of your recovery in order to allow you to accumulate the necessary hours of Covered Employment to re-qualify for eligibility under this Plan, provided:

(a) you have registered for immediate employment under an IBEW Local 6 Collective Bargaining Agreement; and

(b) such extended eligibility does not exceed the above 24-month maximum per a single period of disability.

4. **Successive Disabilities.** For purposes of applying the limitation in paragraph 2, above, successive disabilities shall be treated as a single period of disability unless they arise from:

(a) different and/or unrelated causes, or

(b) the same or a related cause and are separated by at least 3 months of continuous Active employment with a Contributing Employer.

5. **Subsequent Retiree Coverage.** If your temporary disability coverage has continued for the maximum period, you may qualify for Retiree coverage if you meet all of the requirements set forth in II.B.3. on page 11 of this booklet. Periods of temporary disability coverage will be counted for purposes of determining eligibility for Retiree coverage.

C. FAMILY AND MEDICAL LEAVE ACT

You may be eligible for "Family Medical Leave" if you work for an Employer covered by the Family and Medical Leave Act of 1993 ("FMLA") and California Family Rights Act of 1993 ("CFRA"), who has at least 50 employees, and you meet the requirements of the FMLA and/or CFRA as described below. You must have worked for your Employer for at least 12 months and for a total of at least 1250 hours of Covered Employment during the most recent 12 months. Your required Family Medical Leave must be a result of the birth or placement of a child for adoption or foster care to care for your child, spouse or parent or domestic partner with a serious medical condition, or your own serious health condition. Plan benefits will be continued during Family Medical Leave; however, you will be required to continue to make any co-payments normally required under the Plan for maintenance of coverage.

If you are currently working in Covered Employment and exercise a right to Family Medical Leave:

1. any hour bank reserve standing to your credit shall be frozen as of the last day of the month in which the leave begins;

2. your then current Employer shall be responsible for continuing remitting to the Plan the hourly contributions required under the applicable Collective Bargaining Agreement until the earlier of:

(a) the date the maximum statutory leave period (12 work weeks during any

twelve-month period) expires; or

(b) the date you return to Covered Employment (which shall include registration at the Union's referral office);

3. the hour bank reserve, if any, standing to your credit shall be unfrozen on the earlier of:

(a) first of the month immediately succeeding the month in which you return from leave to Covered Employment (which shall include registration at the Union's referral office); or

(b) the date the statuary leave period expires; and

4. upon termination of leave benefits, you shall not lose membership status and may exercise any coverage continuation program available generally to members of the Plan including direct self-payments, disability extension and COBRA.

D. CONTINUED COVERAGE WHILE IN UNIFORMED SERVICE USERRA RIGHTS

If you are an Active employee and called to active military service in the Armed Forces of the United States, you are entitled to certain rights, including continued health care coverage for a up to a maximum of 24 months from the date that service commences.

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") is the primary federal law that provides employment and benefit protection for Covered Employees who are absent from Covered Employment because of certain military service. This subsection is meant to and shall be interpreted to comply with the minimum requirements of the USERRA.

1. **Eligibility Rules for USERRA.** To qualify for USERRA re-employment rights, including certain limited health care benefits (summarized below) you must be a Covered Employee and meet the following requirements:

(a) Purpose of Leave. Your departure from civilian employment is for the purpose of entering a "uniformed service." Uniformed service includes the Army, Navy, Air Force, Marine Corp., Coast Guard, National Guard (full time duty only), Commissioned Corps of the Public Health Service and anyone else designated as covered by the President of the United States during the time of war or National Emergency.

(b) Employee Must Provide Prior Notice of Service. Before leaving for uniformed service, you must provide prior notice that your absence will be due to participation in a uniformed service. Written notice is not required. You are strongly urged to notify the dispatch office of IBEW Local 6, your last Employer, and the Plan Office so that the uniformed service may be noted on the dispatch rolls, and to make the Plan is aware of your situation.

(c) Assert Military Rights for no More than Five Years (with certain exceptions). You may assert USERRA benefits for military absence not to exceed five years. There are limited exceptions to the five-year rule so if you are close to that period, you may contact the Plan Office to determine if your situation may meet an exception to the five-year rule.

(d) Employee Must be Honorably Discharged from Service. You must have been honorably discharged from the military service.

(e) Return to Covered Employment within a Specified Period. You must return to your same Employer or another Contributing Employer within a specified period of time, depending upon the length of time you are absent for military service. The rules for return to employment are:

(i) Service of Less than 31 Days. If your period of military service is less than 31 days, you must be available for Covered Employment on the next calendar day (so long as you had at least eight hours rest after returning home by normal transportation methods) following the end of service.

(ii) Service of More than 30 and Less than 181 Days. If your military service lasts longer than 30 days but less than 181 days, you must be available for Covered Employment (which means registering at IBEW Local 6's dispatch office) no later than 14 days after completion of the military service.

(iii) Service of More than 180 Days. If your leave from Covered Employment for military service exceeds 180 days, you must be available for Covered Employment (register at IBEW Local 6's dispatch office) no later than 90 days after you have completed your military service.

2. **Right to Certain Health Care Benefits Under the Plan.**

(a) Less than 31 Days of Service B One Month of Free Coverage. If you are absent from Covered Employment for less than 31 days, you may elect to continue your coverage under the Plan at its expense.

(b) Absent for More than 30 Days. If you are absent from Covered Employment as a result of military service for more than 30 days, you may elect to purchase COBRA-like coverage for up to 24 months (the first month of which is at no cost to you, regardless of whether or not you elect to make COBRA-like payments). After that first 30 days, you will be required to pay a premium which is 102% of the Plan's cost of the coverage. Typical rights under COBRA are for 18 months, rather than the longer 24 month period for veterans. USERRA's continuation requirements are similar but not identical to COBRA's requirements.

Your absence for military service will trigger rights under both USERRA and COBRA statutes, and you are entitled to protection under the law that provides the most favorable benefit.

(c) Hour Bank Frozen if Requested. Your hour bank reserves under the Plan will be frozen effective with the first of the month following the month that eligibility will be provided from your last hours of employment before entering a uniformed service. For example, if

you last worked in January, you will have your hour bank frozen as of March, with coverage for April provided at the Plan's expense. If you wish to continue coverage for up to the additional 23 months after April, you may then do so by timely remitting monthly COBRA-like payments to the Plan Office. After you return to Covered Employment (with proper notice and documentation), your hour bank will be reinstated in accordance with Plan rules.

SECTION IV: COBRA EXTENSION COVERAGE

A. GENERAL RULES OF COVERAGE

Pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (a federal law known as "COBRA"), you have the right to purchase coverage under this Plan for a temporary period as described below. Your COBRA rights begin on the date of a "Qualifying Event", as set forth in the chart below.

COBRA requires that coverage under this Plan be offered to members or their Dependents as set forth in the box below. Timely payments must be made to the Plan Office of an amount determined by the Board of Trustees, but not to exceed the applicable premium and administrative charges, plus 2% (plus 50% for each month COBRA coverage is extended beyond the 18 months due to total disability). This Plan will treat Domestic Partners as defined in II.C.1.(b), above, as spouses for all COBRA purposes under the Plan.

Qualifying Event	**Qualifying Beneficiary**	**Maximum Extension Period**
Termination of Member's Covered Employment (for any reason other than gross misconduct) or reduction in hours of employment resulting in a loss of eligibility.	Member, Spouse and/or Dependent child(ren)	18 months after date of qualifying event
Death of Member	Spouse and/or Dependent child(ren)	36 months after date of qualifying event
Divorce of Member	Divorced spouse	36 months after date of qualifying event
Dependent ceases to be eligible under terms of the Plan	Affected Dependent	36 months after date of qualifying event
Disability determination under Title II of Social Security Act	Member, Spouse and/or Dependent child(ren)	29 months after date of qualifying event

The maximum COBRA extension period will be offset by any period of coverage under any of the continuation of coverage alternatives set forth in II.D, above, including any period of coverage provided as a result of any hour bank reserves. For example, if after having lost coverage due to

termination of Covered Employment (a qualifying event), you elect to continue coverage under the Plan by making direct self-payments for 6 months. If you are not disabled, you will be eligible for only an additional 12 months of COBRA continuation coverage rather than 18 additional months because the 6 months for which you have made direct self-payments will be included in the standard 18-month maximum COBRA period.

B. SECOND QUALIFYING EVENT

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 provided, however, that the total period of continuation coverage does not exceed 36 months from the first qualifying event, and is offset by any alternate continuation coverage provided under II.D of the Plan. For example, in the event you die after 6 months of being enrolled in COBRA coverage resulting from termination of employment, your spouse and children will be afforded 30 additional months of COBRA coverage, bringing the total number of months of COBRA coverage to the maximum 36 months.

C. EFFECT OF MEDICARE ON COBRA

If you become entitled to Medicare while you are an Active member and, subsequently your coverage under the Plan ends because your Covered Employment terminates or there is a reduction in hours, your Dependents may elect COBRA for the greater of either:

1. 36 months from the date of entitlement to Medicare; or

2. 18 months from the date of termination of Covered Employment or reduction in hours.

If you become entitled to Medicare during the 18-month COBRA period following termination of Covered Employment or reduction in hours, your Dependents are entitled to COBRA coverage for up to 36 months. Regardless of the number of qualifying events or the date of entitlement to Medicare, the maximum period on COBRA is 36 months.

D. COBRA PERIOD NOT COUNTED FOR RETIREE COVERAGE ELIGIBILITY

Any period for which coverage is extended pursuant to COBRA shall not count toward eligible periods required to obtain Retiree coverage.

E. NOTIFICATION REQUIREMENTS FOR DISABILITY OR LOSS OF DEPENDENT STATUS

If COBRA extension coverage is desired by (1) a divorced spouse, (2) a Dependent who ceases to be a Dependent under the Plan, or (3) a disabled member, each must notify the Plan Office within sixty (60) days of the date upon which the above qualifying event occurs that he or she desires to extend coverage pursuant to COBRA.

F. NOTIFICATION REQUIREMENTS IN THE EVENT OF THE DEATH OF A MEMBER OR TERMINATION OF EMPLOYMENT

In the event of your death, if you were eligible for benefits under the Plan at the date of death, the Plan Office will, upon being made aware of such qualifying event, notify your surviving Dependents of the COBRA coverage extension rights and of any alternative options which may be available.

In the event your Covered Employment is terminated and you are otherwise eligible for benefits under the Plan, the Plan Office will notify you and your Dependents of your COBRA coverage extension rights following the last date that you were eligible for non-COBRA continuation of coverage alternatives set forth in Section III, above, including any period of coverage provided as a result of any hour bank reserves.

G. TERMINATION OF COBRA COVERAGE

COBRA coverage will terminate earlier than the maximum period set forth above for COBRA if certain events occur. The following circumstances will cause COBRA to end:

1. **Coverage Under Other Plan.** After you elect COBRA under the terms of the Plan, your COBRA coverage will end on the date you first become covered by another group health plan other than a plan that has a pre-existing condition exclusion or limitation which applies to you.

2. **Medicare Entitlement.** Your COBRA coverage will end on the date you become entitled to Medicare.

3. **Failure to Timely Pay Premium.** Your COBRA coverage will end on the date coverage expires due to nonpayment or delinquent payment of required COBRA continuation payments. A delinquency occurs if:

(a) initial payment is not made within forty-five (45) days after the date the application for COBRA continuation coverage is received in the Plan Office; or

(b) a subsequent monthly payment is not received within thirty (30) days of the due date set by the Plan Office.

4. **No Plan Benefits.** Your COBRA coverage will end on the date the Plan ceases to provide benefits for all members.

5. **Employer No Longer Contributes.** Your COBRA coverage will end on the date your employer who contributed on your behalf ceases to be a Contributing Employer.

H. AVAILABLE COVERAGE OPTIONS

If you are eligible for extension coverage pursuant to COBRA, you may elect either Core coverage only, or both Core coverage and Non-Core coverage. "Core coverage" is medical coverage only. "Non-Core coverage" is dental and vision care coverage where applicable. If Non-Core coverage is elected in addition to Core coverage, all Non-Core coverage will be included. An individual may not

elect dental or vision coverage only.

I. CALIFORNIA COBRA MAY EXTEND RIGHTS

Under California law, HMOs, such as Kaiser or PacifiCare, are required to offer to continue benefits for certain individuals beyond the period of federal COBRA in certain situations. You may contact Kaiser or PacifiCare for information on this program. The HMOs will provide the appropriate notices and options if this becomes applicable to your situation.

SECTION V: HOSPITAL AND OTHER MEDICAL BENEFITS

As a Participant in the Plan, you are given a choice of two HMOs and the Self-Funded Indemnity Plan (Indemnity Plan). You can select from among the three Plans offered, which are Kaiser (HMO), PacifiCare (HMO), and the Indemnity Plan. You are allowed to change your choice of plans once each year.

A. SELF-FUNDED INDEMNITY PLAN

The Indemnity Plan provides you with freedom of choice in selecting your Physician. To maximize Plan benefits, you are urged to use Physicians and Hospitals that are Preferred Providers. When you use health care providers that are not Preferred Providers, you may incur more out-of-pocket costs.

You should carefully review the benefits of the Indemnity Plan to make certain it fits your needs, and that you understand what will be your financial obligation (out-of-pocket costs) under this option.

1. **General Provisions.**

(a) Summary of Benefits.

(i) Deductible. There is a $50 per person, $100 per family per calendar year deductible. (Exception: Non-Medicare-Eligible Retirees: ($100.00 per person, $200.00 per family))

(ii) Hospital Benefit. The Plan pays the first $5,000 of covered Hospital charges in a calendar year at 100% (not subject to the deductible).

(iii) Other Medical and Hospital Benefits. The Plan will pay 80% of Covered Charges after the deductible is met.

(iv) Out-of-Pocket Maximum. There is an out-of-pocket maximum of $1,000 per person per calendar year. (Prior to January 1, 2007, the out of pocket maximum was $1,000.) The Plan will pay 100% of Covered Charges in excess of $5,000 per person in a calendar year.

(v) Annual Maximum. There is an annual maximum of $500,000 per person

(vi) Maximum Lifetime Benefits. There is a lifetime maximum of $2,000,000 per person (including benefits for both Actives and Retirees).

If you or your Dependent incurs Covered Charges during a calendar year as a result of a non-occupational Illness or Injury sustained while eligible, benefits will be paid at the appropriate percentage of Covered Charges, subject to the limitations and provisions in this booklet.

You and your Dependents are encouraged to review the Plan Comparison Worksheets that are

available in the Plan Office when deciding which Plan would most meet your needs, either at the time of initial enrollment or during open enrollment.

(b) Preferred Provider Network. The Plan has contracted with First Health Group Corp., a Delaware corporation, ("First Health"), to access the First Health Preferred Provider Organization ("PPO") Network, to cover Hospital and medical services rendered by participating Hospitals and practitioners at predetermined fees. Neither you nor the Plan is responsible for any charges in excess of the contracted amount. The Plan adopted this PPO Network as a cost containment measure and the result is a saving to both the Plan and the members who use participating providers and facilities. Additionally, some services that are not normally covered under the Plan may be included at no charge at a PPO Network facility. Information regarding this program, as well as a schedule of providers, is available by phoning First Health at 1-800-226-5116 at no cost or you may access this information directly through First Health's web-site at www.myfirsthealth.com.

(c) Medically Necessary Requirement. Charges must be Medically Necessary in order for the charge to be covered under the Plan. **NOTE: 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 may order treatment does not, of itself, make it Medically Necessary, or make the expense a Covered Expense.** (See Section XIV, *Definitions.*)

2. **Benefits for Active and Early Retiree Members and Their Dependents.**

The Plan has contracted with First Health Group Corp. to provide Clinical Management Services including utilization review and case management.

Early Medical Assessment. Medical providers and hospital facilities are requested to contact First Health prior to any non-emergency hospitalizations and outpatient procedures at (800) 572-5508. Pre-notification ensures early identification of high-risk patients that would benefit from case management through a detailed data collection process. This procedure is not designed to interfere with medical decisions made between patients and their providers.

Medical Case Management. This service is designed to assist you or your Dependent in obtaining needed medical care from the most appropriate source available. The care manager will have the option of scheduling services or suggesting methods and providers of care, which may not be specifically covered by this Plan. The costs of these special care facilities and treatments will be treated as "Covered Charges" and reimbursed as outlined below. Referrals into case management will come from First Health's early medical assessment program and the Plan Office.

(a) Medical & Hospital Benefits. After the deductible has been satisfied, the benefits will be paid at 80% of the first $5,000 of incurred Reasonable and Customary charges in a calendar year as defined in the Section XIV of this booklet. The 20% balance (member's coinsurance) is an out-of-pocket expense for which you are responsible. Once you or your Dependent has incurred $5,000 in Covered Medical and Hospital Charges in a calendar year, the Plan will pay the balance of Covered Charges incurred during the remainder of the calendar year at100%. (Prior to January 1, 2007, the Plan paid 80% of the first $7,500 and 100% after $7,500 in incurred Reasonable

and Customary charges in a Calendar Year.)

Effective, January 1, 2007, the Plan pays the first $5,000 of covered Hospital charges in a calendar year at 100% (not subject to the deductible) when a member or Dependent:

(i) is a registered bed patient, (including room and board charges up to the semiprivate rate); or

(ii) receives emergency outpatient treatment at a Hospital within 24 hours from the occurrence of an accident; or

(iii) receives emergency outpatient treatment for a condition characterized by acute symptoms that are of sufficient severity to cause a reasonable expectation, in the absence of immediate medical attention, that the health of the individual is in serious jeopardy; or

(iv) requires Hospital facilities as an outpatient for a surgical operation.

Successive Hospital confinements shall be considered one confinement unless (1) they are separated by 30 days or (2) readmission is required as a result of accidental bodily injury during the 30 days. The Trustees have the authority and discretion to interpret, construe and apply the terms of the Plan and to decide any and all other issues arising under the Plan, including the amount of benefits (if any) that may have become payable.

(b) Exception. The following benefits are paid at 100% of the Reasonable and Customary charges and are not subject to deductible or maximum amounts payable.

(i) Second Surgical Opinion. You may consult a legally qualified Physician on the need of a non-emergency surgical procedure which is otherwise covered under the Plan, including necessary x-ray and laboratory examinations. If the second opinion does not confirm the need for the surgery you may consult a third Physician. Charges incurred for the second and/or third consultation for surgery will be payable at 100% of the first $100 per consultation. For any Reasonable and Customary charges incurred in excess of $100 for the second or third consultation, reimbursement shall be subject to the deductible amount, percentages payable, and maximum amount payable.

(ii) Convalescent Hospital and Skilled Nursing Facility expenses are reimbursable after an in-patient Hospital confinement of at least 3 days, up to a maximum of $75.00 per day. The maximum number of Convalescent Hospital days during any one period of confinement is 100, reduced by the number of days of Hospital confinement. Successive Hospital confinements (including Convalescent Hospital confinements) will be considered a single confinement unless they are separated by a period of 30 days or the second confinement is due to a

new accidental injury. The Plan will not reimburse expenses in excess of $75.00 per day.

(c) Deductible Amount. The deductible is $50 per person up to a maximum of $100 per family for each calendar year. This is the out-of-pocket expense for which you are responsible. Non-Covered Charges and your coinsurance percentage may not be used to satisfy the deductible amount.

The deductible amount is subtracted from the Covered Charges and the remaining amount is multiplied by the coinsurance percentage to determine the 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 two or more individuals in an eligible family have satisfied the family deductible in a calendar year, no further deductible is required of that family unit for charges incurred in the remainder of that calendar year. "Eligible family" means a covered member and all Dependents.

(d) Maximum Payment. The maximum amount payable in a calendar year for all illnesses or injuries for any one eligible member or Dependent shall not exceed $500,000 per calendar year and $2,000,000 per lifetime. Each January 1st, the amount of major medical benefits which was used in the preceding calendar year will automatically be reinstated up to a maximum of $1,000. This reinstatement is made without any action required on your part. However, in no event will the total cumulative benefits, including the amount reinstated, exceed the original lifetime maximum. There will be no automatic reinstatement when benefits are being continued under the Non-COBRA Continuation of Coverage provisions. (See III, page 21.)

3. **Benefits for Retirees and Their Dependents.**

(a) All benefits described in II.A.1, *Benefits for Active and Early Retiree Members and their Dependents* also apply to Retirees and Dependents.

(b) If you are a Retiree member but are not yet eligible to enroll in Medicare, the annual deductible is $100.00 for you and $200.00 per family.

(c) If you are a Medicare-eligible Retiree or Dependents, the Plan shall offset Covered Charges by the amount payable by Medicare. Payments made pursuant to Medicare are subject to the satisfaction of any deductibles and the application of any Plan benefit maximums or coinsurance.

(d) If you are a Retiree member or Retiree Dependent covered under the Indemnity Plan, once you or your Dependent becomes eligible to enroll in parts A & B of Medicare, the Plan will process eligible claims incurred on or after that date as though you or your Dependent has Medicare coverage, even if you or your Dependent fails to enroll or is treated by a non-Medicare certified provider.

(e) If you are a Retiree member, and you or your Dependent selects and assigns

your (or your Dependent's) Medicare Parts A & B to a plan outside the Plan, no benefits will be payable unless the supplemental benefits described in Section VII are selected.

4. **Covered Charges.** Benefits are payable for the Reasonable and Customary charges for services ordered by a Physician or other Licensed or Certified Health Care Provider that are Medically Necessary and are for services, treatment, and supplies for the care and treatment of an Illness or Injury.

The Plan will pay benefits as outlined in III.A.1 and III.A.2 for the following charges:

(a) Treatment. Made by a duly constituted and lawfully operated Hospital for outpatient and inpatient treatment. Covered Charges for inpatient treatment are limited to the Hospital's regular rate for semiprivate accommodations. If the Hospital does not have semiprivate accommodations, the Plan will pay 75% of the minimum daily charges for room and board.

(b) 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 outpatient 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 cancelled or delayed, the benefit will still be paid if:

(iv) the tests reveal a condition that requires treatment prior to the admission;

(v) a medical condition develops that delays the admission;

(vi) a hospital bed is not available on the scheduled date of admission; or

(vii) the tests indicate that the admission is not necessary.

(c) 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.

(d) Licensed Convalescent Hospital or Skilled Nursing Facility. Made by a Licensed Convalescent Hospital or Skilled Nursing Facility as defined in Section XIV, *Definitions* and subject to the limitations described above in A.1(a)(ii).

(e) Professional Medical Services. For professional medical services of a

Physician (including surgeon, anesthesiologist, radiologist, pathologist) or Other Licensed or Certified Health Care Provider as defined in Section XIV, *Definitions*.

(f) Chiropractor. For Reasonable and Customary charges by generally accepted chiropractic standards when treated by a licensed chiropractor. You should contact the Plan Office for an evaluation before starting treatment because the number of visits is limited depending upon the nature of 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.

(g) Acupuncturist. For Reasonable and Customary charges of a licensed acupuncturist which may be covered as a standard medical benefit for Reasonable and Customary expenses, depending upon the diagnosis. You should contact the Plan Office prior to scheduling treatment to determine whether or not coverage is applicable to your specific 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.

(h) Therapist. For Reasonable and Customary charges of a licensed or registered physical therapist or occupational therapist. You should contact the Plan Office for an evaluation before starting treatment since the number of visits may be limited depending upon the nature of 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.

(i) Mental Health. For professional services of a licensed psychologist, psychotherapist or psychiatrist for treatment of mental and nervous disorders and emotional disturbances of a child. These benefits are provided through an insured program with PacifiCare Behavioral Health. This supplemental program is described in Section VII.

A "child" within the meaning of the phrase, "emotional disturbances of a child" means a child who:

(i) is under age 18; and

(ii) has one or more mental conditions as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior that is inappropriate to the child's age according to expected developmental norms if:

(I) as a result of the mental condition the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationship or the ability to function in the community; and either of the following:

(A) the child is at risk of removal from home or has already been removed from the home; or

(B) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(II) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or

(III) the child meets special education eligibility requirements under Chapter 26.5 of Division 7 of Title 1 of the Government Code.

(j) Nursing. Made by a registered nurse (R.N.), a licensed vocational nurse (L.V.N.), or licensed practical nurse (L.P.N.), for private duty nursing service.

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

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

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

(n) 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 Food and Drug Administration ("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; (iii) not be primarily used for non-medical purposes; and (iv) not be specifically excluded by the Plan.

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

(p) 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.

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

(r) Laboratory Tests and X-Rays. For laboratory tests and x-rays.

(s) Anesthesia. For anesthesia and its administration.

(t) Cancer Treatment. For use of radium and radioactive isotopes and/or cancer

chemotherapy treatment.

(u) Ambulance/Transportation. For transporting the patient to the first Hospital where treatment is given and when Medically Necessary, if such transport:

(i) is to the nearest facility equipped to provide the required treatment;

(ii) is provided by a licensed professional ambulance service; and

(iii) is land transportation except where land transport is too dangerous or is not available.

(v) 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 RxAmerica's prescription drug card program - see *Supplemental Benefits*, Section VII, page 52).

(w) Injectable Drugs. For injectable drugs, including syringes and needles for the administration thereof.

(x) Substance Abuse. For substance abuse, including detoxification. These benefits are provided through an insured program with PacifiCare Behavior. This supplemental program, which is available to all Plan Participants and their Dependents, is described in VII.E and VII.F, below on pages 57-58.

(y) Tempomandibular Joint Dysfunction. For the treatment of Tempomandibular 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, if the procedure is Medically Necessary to treat a condition caused by congenital deformity, Injury or Illness. However, charges for intra-oral prosthetic devices are excluded. Benefits for TMJ may not exceed a lifetime maximum of $1,500.

(z) Maternity Charges. For maternity-related services for a member or spouse or Domestic Partner. Maternity charges incurred by a Dependent child are not covered, except for complications of pregnancy, defined in clause (i) below. Charges due to elective abortion shall not be considered a Covered Expense except for those charges incurred for an abortion where the life or health of the mother would be endangered if the fetus were carried to term, or those charges which 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 visit" at the time of release from the Hospital.

(i) **Complications of pregnancy** means:

(I) conditions that require Hospital confinements (when the pregnancy is not terminated), whose 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 which is

terminated; and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

(ii) A female member or Dependent spouse or Domestic Partner who is pregnant on the date of termination of her coverage will be entitled to the applicable benefits for covered expenses 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.

(iii) Charges for maternity-related care will be provided on the same basis as any other Illness. However, expenses for inpatient Hospital treatment for childbirth delivery will be provided for the mother's newborn child for:

(I) 48 hours following normal vaginal delivery; and

(II) 96 hours following delivery by Caesarean section.

(iv) The mother and newborn child may be discharged earlier than the above indicated time periods if both of the following conditions are met:

(I) the treating Physician or Other Licensed or Certified Health Care 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, when:

(A) prescribed by her treating Physician; and

(B) the visit is provided by a Licensed or Certified Health Care 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.

(aa) Gynecological. For annual routine pap smears including a gynecological

exam.

(bb) Mammography. For mammography screening as follows:

(i) a single baseline mammogram for women age 35, but less than 40

(ii) one mammogram every two years, or more frequently if recommended by a Physician, for a woman age 40, but less than age 50; and

(iii) one mammogram every year for a woman age 50 or older.

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

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

(ee) Annual Physical. For an annual physical up to a maximum of $300.

(ff) Preventive Child Care. For preventive child care which will be considered Medically Necessary for the following services:

(i) Physician's services for routine physical examinations;

(ii) immunizations; and

(iii) laboratory services in connection with routine physical examinations.

(iv) Benefits will be limited to one Physician's visit, including immunizations and laboratory services in connection with such visit at approximately the following ages:

(I) birth;

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

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

(gg) Newborn. For Newborn care, limited to one well baby Hospital visit.

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

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

(jj) 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.

(kk) Adult Immunizations. Charges for immunizations for adults. Benefits are limited to immunizations that are recommended by the American Academy of Family Physicians or the patient's Physician.

(ll) Schedule of Transplant Benefits. The following schedule summarizes coinsurance amounts paid by the Plan, benefit maximums and additional explanations needed for your transplant benefits. Please refer to the other Plan provisions that may affect your benefits.

Benefit Description	First Health$_7$ National Transplant Program	Non-National Transplant Program	Additional Limitation and Explanations
Plan Pays	100%	Not Covered	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 National Transplant Program will not be covered, including any donor expenses or travel, lodging and meals related to the transplant.
Organ Donor Costs Per Transplant	$100,000	Not Covered	
Travel, Lodging and Meals Allowance Per Transplant	$10,000	Not Covered	
Individual Lifetime Benefit Maximum	$1,000,000	Not Covered	

First Health National Transplant Program/Member Services toll-free number: 1-800-572-5508

NOTES: Please refer to the separate flyer regarding the First Health$_7$ National Transplant Program for additional information about the program.

Transplant benefits are subject to the medical plan lifetime benefit maximum on the Schedule of Medical Benefits.

B. MEDICAL PLAN LIMITATIONS AND EXCLUSIONS

The benefits of this Plan are provided only for services and supplies that are Medically Necessary. These services are covered services and supplies that are consistent with the symptoms or diagnosis in the treatment of an Illness or Injury, are Medically Necessary and consistent with generally accepted professional standards, are not furnished primarily for the convenience of the patient, the Physician, or other provider, and are furnished at the most appropriate level which can be provided safely and effectively to the patient. Examples of services that are not Medically Necessary include hospitalization for diagnostic studies that could have been provided on an outpatient basis, hospitalization primarily for observation or evaluation, hospitalization to remove the patient from his or her customary work and/or home environment or for personal comfort.

The Plan reserves the right to determine if a service, supply, or hospitalization is Medically Necessary. The fact that a Physician or other provider has prescribed, ordered, recommended or approved a service, supply, or hospitalization does not, in itself, make it Medically Necessary.

The following charges are NOT Covered Charges/Expenses:

1. **Excess of Reasonable and Customary.** Any portion of a charge which 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. To determine this, the Plan may rely upon the advice of its medical review department and/or an independent medical reviewer and other medical experts. This provision shall not exclude any Covered Expense which specifically states that such treatment will be considered Medically Necessary.

3. **Experimental or Not Generally Accepted Treatment.** Charges incurred for a treatment that is not generally accepted by the medical profession, or is listed as Experimental, under Investigation, or limited to research:

(a) by the FDA; the American Medical Association ("AMA"); Diagnostic and Therapeutic Technology Assessment ("DATTA"); or the Office of Medical Application of Research of the National Institute of Health Office of Technology Association ("OMT"); or

(b) if a treatment has not been addressed by one of the organizations listed in a. above, the Plan has the right to determine if a treatment is appropriate based on the advice of its medical review department and/or an independent medical reviewer and other medical experts.

However, coverage will not be denied for an FDA-approved drug which is used to treat a condition for which the FDA has not approved the drug's use, if all of the following conditions have been met:

(c) The drug is prescribed for the treatment of a life-threatening condition. "Life-threatening" means either or both of the following:

(i) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; and/or

(ii) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(d) The drug has been recognized for treatment of that condition by one of the following:

(i) the American Medical Association Drug Evaluations;

(ii) the American Hospital Formulary Service Drug Information; or

(iii) the United States Pharmacopeia Dispensing Information, Volume I, "Drug Information for the Health Care Professional".

4. **Certain Eye Surgery.** Charges incurred for surgery to the eye to correct a retroactive error, such as radial keratotomy; charges incurred for the purchase or fitting of eye glasses or contact lens. However, charges incurred for a contact lens or eye glasses and frames required immediately following and as a result of cataract surgery will be a Covered Expense.

5. **Cosmetic Charges.** Charges incurred in connection with treatment that is Cosmetic; other than:

(a) reconstructive surgery to restore tissue damaged by Injury or Illness, including surgery on one or both breasts to reestablish symmetry following a mastectomy; or

(b) treatment of a child from birth to correct a congenital disease or anomaly, including an oral defect.

6. **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.

7. **Custodial Care.** Charges incurred for Custodial Care.

8. **No Legal Obligation to Pay.** Charges which a member is not legally obligated to pay for; or treatment which he or she obtains, or is entitled to obtain, under any Plan or program without charge, except 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:

(a) an Injury or Illness related to the patient's military service; or

(b) the member or his or her Dependents, if retired from the armed services.

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

10. **Work-Related.** Charges incurred as a result of:

(a) an Injury which arises out of or in the course of any employment with any other employer; or

(b) an Illness for which the member or Dependent

(i) is entitled to benefits under any workers' compensation law or occupational disease law; or

(ii) receives any settlement from a workers' compensation or occupational disease carrier.

11. **Third Party Responsible**. Charges incurred for which a third party tortfeasor is responsible; however, benefits may be advanced from this 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.

12. **Transportation.** Charges for transportation, except professional ambulance services.

13. **Artificial Birth Methods.** Charges incurred in connection with:

(a) artificial insemination;
(b) in vitro fertilization; or
(c) in-vivo fertilization;

14. **Personal Comfort Items.** Charges for personal comfort items B 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.

15. **Certain Newborn Well-Baby Care.** Newborn well-baby care except for a "well-baby" Physician's Hospital visit or where included in a PPO Network Hospital contract.

16. **Vitamins, Dietary Supplements, Weight-Control, Beauty Aids.** Charges for multiple and non-therapeutic vitamins, dietary supplements, weight-control items, and health and beauty aids are not Covered Expenses, nor is any drug which is not Medically Necessary for the care of treatment of an Illness or Injury.

17. **Same Household.** Charges made by an individual who usually lives in the same household as the Participant or the Participant's Dependent, or who is a member of the immediate family or the spouse's immediate family.

18. **Hearing Aids.** Charges for hearing aids.

C. SPECIAL RULES-FEDERAL MANDATE

1. **Women's Health and Cancer Rights Act of 1998.** On October 21, 1998, President Clinton signed a federal law called the Women's Health and Cancer Rights Act of 1998. Under this federal law, group health plans, insurers and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive breast surgery. For a Participant or beneficiary who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending Physician and the patient for (a) reconstruction of the breast on which the mastectomy was performed, (b) surgery and reconstruction on the other breast to produce a symmetrical appearance, and (c) prostheses and physical complications of all stages of mastectomy, including lymphedemas. This coverage is subject to the Plan's annual deductibles and coinsurance

provisions.

2. **Newborn's and Mother's Health Protection Act.** Group health plans and health insurance issuers generally may not, under federal law, 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, Plans and issuers may not, under federal law, 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).

3. **Health Insurance Portability & Accountability Act.**

(a) Certificate of Coverage. The Health Insurance Portability Accountability Act of 1996 ("HIPAA") provides that group health plans must limit the time for which coverage is not provided for pre-existing conditions. (This Plan has no such exclusions but some other plans do.) The law also provides that your coverage under this Plan will reduce the pre-existing condition limitation period of another plan for which you become eligible. For example, if the other plan has a 12-month pre-existing condition limitation and you have been eligible under this Plan for 12 consecutive months prior to becoming eligible under the other plan, the pre-existing condition limitation of the other plan will not apply to you.

When you experience a qualifying event under this Plan, the Plan Office will transmit to you, along with your initial COBRA notice, a certification of the number of months for which you and your Dependents have been eligible for benefits under this Plan. The certificate of former group health plan coverage provides evidence of your health coverage under this Plan. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll. If you are eligible for coverage due to new employment, you may want to furnish a copy of this certificate to your new employer in order that you can become eligible for the greatest number of benefits due to employment as quickly as is possible.

You and/or your new employer should contact the Plan Office if any additional information certifying your coverage under this Plan is required. Once you become eligible under another plan that has no pre-existing condition limitation which limits the coverage available to you, your rights to continue coverage under this Plan pursuant to COBRA terminates.

(b) Privacy and Security. This section explains the Plan's use and disclosure of health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). 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 privacy and security rules apply only to health benefits.

The Plan (through 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. The Plan will also use and disclose PHI and Electronic PHI as required by law and as 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 and SARs).

The Plan (through EISB) will disclose PHI to the Board of Trustees only pursuant to an authorization or for Plan administration after receipt of a certification from the Board of Trustees 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 of Trustees 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 of Trustees 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 of Trustees 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;
- incorporate amendments to PHI and Electronic PHI in accordance with HIPAA;
- 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;
- 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 of Trustees 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.

D. COORDINATION OF BENEFITS

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans are paying for the same claim. To help control costs, the Plan provides for the coordination of benefits.

1. **How Does Coordination Work?** If you or your Dependents are also covered under another group plan, the total amount received from all plans will never be more than 100% of the Covered Expenses as defined in Section XIV, *Definitions*. Benefits are reduced only to the extent necessary to prevent any person from making a profit.

This Coordination of Benefits provision shall not apply to any private coverage which you or your Dependents purchase individually.

2. **Which Plan Pays First?** If both plans have Coordination of Benefits provisions, such as this one, the plan that insures you as a member pays first. If you are insured as a member under two plans, the plan which has insured you longer is the primary. However, if you are insured as an Active member under one plan and a laid-off employee or as a retiree under another plan, the plan that insures you as an Active member will pay its benefits first; this does not apply if either plan does not have a provision regarding laid-off or retired members. If one plan does not have a Coordination of Benefits provision, that plan is always primary. If a Dependent child is covered under two plans, the plan of the parent whose birthday occurs earliest in the year will pay benefits first. However, if the parents are divorced or are separated, the plan of the parent with custody pays benefits first. In the event of qualified joint custody, the plan of the parent whose birthday occurs earliest in the year will be the primary. 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 divorce decree child support order directs one of the parents to be financially responsible for the medical, dental or other health care expenses of the child.

3. **Coordination with Medicare.** Coverage under this Plan will be secondary if you are eligible for Medicare and you are a retired member or a Dependent of a retired member.

Coverage under this Plan will be primary if you are eligible for Medicare and you are:

(a) an Active Participant and over age 65; or
(b) over age 65, a Dependent and your spouse is an Active member.

In each case, where this Plan continues as the primary carrier, the Plan will pay first and Medicare will pay second. However, you and your spouse have the option of electing Medicare as primary. **Please note: If Medicare is elected as primary, coverage under this Plan will cease as required by Federal Law.**

4. **Medicare Benefits Due to Total Disability.** The following rules apply with respect to the coordination of benefits with Medicare if you or your Dependent becomes entitled to Medicare benefits prior to age 65 due to total disability or end stage renal disease. Upon attainment of age 65, the rules for coordination of benefits with Medicare at age 65 apply.

This Plan will be a primary Plan to Medicare during any waiting period for Medicare benefits due to total disability or end stage renal disease. After the Medicare waiting period has been met, and you or your Dependent is entitled to Medicare benefits, this Plan will be secondary, with one exception: except that the Plan will be primary to Medicare if you are an Active member, and you or your Dependent is entitled to Medicare benefits due to total disability for other than end stage renal disease; however, the Plan will be secondary to Medicare if you are an Active member, and you or your Dependent is entitled to Medicare benefits due to end stage renal disease.

5. **Right to Obtain or Release Information.** The Plan may obtain or release any information necessary to implement these provisions. 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 provision 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 provision from you from an insurance company, or from another 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.

E. SUBROGATION AND REIMBURSEMENT OF BENEFITS ADVANCED FOR WHICH A THIRD PARTY IS RESPONSIBLE

In general, the Plan does not cover you if you need medical treatment for a condition caused by a third party, such as injuries incurred in an automobile accident that is not your fault. However, the Plan will advance payment for your treatment if you agree to reimburse the Plan for any benefits that are the responsibility of a third party. You also must assign to the Plan your right to recover from the third party to the extent of any benefits paid on account of your condition. This subsection explains these rules, applies to your Dependents as it applies to you, and applies to the

third party's insurer as it applies to the third party.

1. **Agreement by Acceptance of Benefits.** By accepting benefits from the Plan for any condition for which a third party may be legally responsible, you agree that:

(a) the Plan is automatically assigned your right to sue the third party to the extent it is responsible for those benefits;

(b) the Plan may intervene at any time in any lawsuit (or other proceeding) you bring against the third party in connection with the event that contributed to your condition;

(c) you will reimburse the Plan from any amounts you recover from the third party relating to your condition to the extent of your benefits; and

(d) the Plan has an automatic lien upon any amounts you recover from the third party to the extent of your benefits.

This subsection generally applies to any no-fault insurance recovery (such as workers' compensation), and any proceeding brought against a third party for its negligent acts or omissions.

2. Conditions to Receipt of Benefits. As a condition to your receipt of Plan benefits and to any further eligibility under the Plan, you agree to:

(a) notify the Plan within 30 days of commencing any lawsuit (or other proceeding) against a third party for damages or other remedy on account of a condition for which Plan benefits may be paid, including the important facts and background of the lawsuit;

(b) furnish any information or assistance that the Plan may reasonably require to enforce its rights under this subsection; and

(c) take no action that may prejudice or interfere with the Plan's rights under this subsection.

3. Subrogation. Subrogation is the right of the Plan to step in the shoes of a Covered Person to pursue directly an action against a third party who may have injured that Covered Person (such as in an automobile accident) for recovery of medical benefits paid by the Plan.

To the extent the Plan pays any benefits on your behalf, it is subrogated to all related recovery rights you may have against any third party or under any no-fault insurance coverage, regardless of whether you obtain a full or partial recovery from the third party and without offset for any costs you may incur pursuing a claim against the third party. The Plan's subrogation right (i) takes priority over any right of recovery you hold against the third party arising out of the event that caused the Plan to pay your benefits, (ii) is for the full amount of your benefits paid by the Plan and (iii) applies whether or not you receive (or are entitled to receive) a full or only a partial recovery from the third party. You may not release any third party from its responsibility for any Plan benefits provided to you without the written approval of the Plan. If you pursue a claim against any third party, you agree to include any subrogated interest of the Plan in that claim. If you do not, the Plan is presumed to be included in that claim. If you do not pursue a claim against a third party in which the Plan has a subrogation right, the Plan may independently pursue or settle the claim.

4. Reimbursement. Reimbursement is the Plan's right to pursue an action against a Covered Person who has already recovered on claim for health benefits against the third party.

To the extent you recover from a third party on a claim that resulted in a payment of Plan benefits for which the third party is responsible, you will use the recovery to reimburse the Plan up to the amount of the medical benefits paid by the Plan. This Plan reimbursement right applies (i) first priority, (ii) without offset for any costs you incur to obtain the recovery, (iii) whether or not you received a full or partial recovery and (iv) whether or not you have been "made whole" by reason of the recovery. If you are paid any money or property by a third party as a recovery for a claim described in this subsection, you agree to hold any such amounts in trust for the Plan's benefit. If you do not reimburse the Plan as required in this subsection, you will be personally liable for all costs associated with the Plan's attempt to recover from you. You also agree to assist the Plan fully (including the timely execution of appropriate documents) to allow the Plan to enforce its reimbursement rights. Unless expressly agreed otherwise, the Plan is not responsible for any fees or costs you may incur should you pursue a claim against a third party. The Plan's reimbursement rights hereunder are not subject to offset for any costs you incur pursuing a claim against the third party.

5. Other Matters

(a) You Must Provide Claim Information. When you submit a claim to the Plan, you must complete appropriate forms, including a form requesting:

(i) how the injury or illness occurred;

(ii) the identity of any potentially responsible third parties, including their insurer, adjusters and claim numbers;

(iii) any accident report; and

(iv) an assignment of your interest in any third party recovery relating to your claim to the extent the Plan has a subrogated interest.

(b) Recovery by Plan. The Plan may offset any future benefit payments to you in the amount of any outstanding lien. If the Plan pays your benefits and, for whatever reason, benefits were not covered under the Plan, the Plan may recover those payments in any lawful manner, including offsetting any future benefit payments to either you or your Dependents.

(c) Make Whole Doctrine. The Plan does not apply the "make whole" doctrine applied by some state courts, and that might otherwise require that you be "made whole" before the Plan may benefit from its subrogation or reimbursement rights.

SECTION VI: HEALTH MAINTENANCE ORGANIZATIONS

In place of the medical benefits provided by the Indemnity Plan, as described above, you may select an HMO. An HMO consists of a network or health care providers who have contracted with Kaiser ("Kaiser") or PacifiCare of California ("PacifiCare") to provide medical services to eligible Participants. Each HMO has descriptive literature, which explains the services and benefits provided, as well as the plans' limitations and exclusions.

The HMO you select (Kaiser or PacifiCare) will provide you with complete descriptive literature 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.

To enroll in an HMO, you must live or work within the HMO's service area. For Kaiser, your home or principal place of work zip code must be included within Kaiser's zip code listing. For PacifiCare, you must live or work within a 30-mile radius of the Medical Group selected.

Under the HMO plans, covered services are generally provided for a fixed co-payment.

Not all of these plans are available to all Participants because their service areas may not include the area in which the Participant lives. Participants who wish to elect or discontinue coverage in any of the HMO plans may do so during the plan's open enrollment period, which will occur during the months preceding the month plan changes are to be implemented. Plan changes are effective from and after August 1st of the year in which the election is made (or after such other enrollment periods that the plan offers).

If you elect an HMO, none of the medical benefits described in this booklet will apply to you with the exception of the supplemental benefits described below in Section VII. Because each HMO has its own appeal procedures, the claims review procedures described in this booklet will also not apply to you for benefit claims. You must refer to the applicable HMO's individual plan descriptions to determine what benefits are available and, in the event of a full or partial denial, its specific appeal procedures. Further, you should be aware that any claim for malpractice under these plans is generally subject to the arbitration procedures set forth in the contract between the Trustees and the HMO. Further information may be obtained from the Plan Office or directly from the HMO provider.

Supplemental benefits that are available to you regardless of which plan you select include, dental (including orthodontia), vision, mental health and chemical dependency treatment, and death benefits. These are benefits described in Section VII below.

The following HMO options are presently available:

PacifiCare of California/ PacifiCare-Secure Horizon 5701 Katella Avenue Cypress, CA 90630-5082 800-624-8822 800-322-8877 Secure Horizon	Kaiser Foundation Health Plan, Inc. /Senior Advantage 1950 Franklin Oakland, CA 94612 800-464-4000 800-777-1238 Senior Advantage

SECTION VII: SUPPLEMENTAL BENEFITS

In addition to the medical benefits previously described in this booklet, the Plan provides certain supplemental benefits. Medicare-eligible members have the option of selecting these supplemental benefits only. Separate booklets are available for dental and vision benefits. The following represents a summary of the supplemental benefits and programs now available:

A. DISCOUNT PRESCRIPTION DRUG CARD PROGRAM (APPLICABLE TO INDEMNITY PLAN ENROLLEES ONLY)

1. **Rx America Program-20 Percent Co-Payment.** Indemnity Plan prescription drug benefits are covered through RxAmerica's prescription drug card program. Most of the major pharmaceutical chains and many independent pharmacies participate in this program. (Kaiser and PacifiCare participants obtain their drugs through their HMO.)

To use the program, you present your RxAmerica Identification Card to a pharmacist with your prescription. The pharmacist will process your prescription electronically through an on-line system. At the time your prescription is filled, the pharmacy will collect a **20% co-payment** of a discounted prescription drug price from you.

The RxAmerica pharmacy program includes a closed drug formulary, which is a list of prescription medications that reflects the most current clinical judgment of health care providers for promoting high quality and affordable medical treatment. In most situations, drugs that are not included on RxAmerica's formulary may be obtained through the program at an additional cost.

ALERT: MEDICARE-ELIGIBLE RETIREES

Medicare-eligible Retirees are eligible for a new prescription drug program under Medicare Part D effective as of January 1, 2006. Your coverage in the current prescription drug plan provided through the Plan (whether you are in the Indemnity Plan or one of the two HMO plans) is not affected by the new Medicare prescription drug program. You continue to have coverage under the Plan's drug program; therefore, **it is not necessary for you to enroll in Medicare Part D offered outside of the Plan with a non-Plan provider**. If you choose to enroll in a Medicare Part D program outside of the Plan, you will lose coverage under the Plan's medical programs (e.g., Indemnity Plan, PacifiCare Secure Horizon or Kaiser Senior Advantage) but your dental and vision supplemental benefits coverage will not be affected. You will not be allowed to re-enroll in one of the Plan's medical programs until the next open enrollment period.

The prescription drug benefit you currently receive under the Plan provides better coverage, at less cost to you, than the new drug program under Medicare Part D. As long as you are eligible to have prescription drug coverage through the Plan, you are considered to have creditable coverage; therefore, if at some later date you choose to enroll in Medicare Part D, you will not be charged a late penalty for delayed enrollment.

Please note that while the Plan advises you NOT to enroll in Medicare Part D at this stage, you must still enroll for both Medicare Part A and Part B to be eligible for full coverage in this Plan.

2. **Generic Drugs vs. Brand Name Drugs.** The 20% co-payment applies whether you purchase brand name or generic drugs; however, the lower the cost of the drug, the greater the savings to you and the Plan. As a general rule, a new drug is given both a brand and generic name. The brand name is what the manufacturer calls the product. The generic drug is the name of the drug's chemical compound in most instances. Most generic drugs are less expensive than brand name products. When a company develops a new drug, it has a patent for a specified period, which permits the drug company to be the only manufacture of that drug. After the patent expires, other companies can manufacture and sell the drug under a different brand name or the generic name. The new product is often sold at a lower price than the original brand name product. You may want to ask your Physician if a comparable generic drug is available.

Most eligibility problems are resolved at the time your prescription is filled. If not, you may be required to pay full price. If you are subsequently credited for eligibility for a month in which you paid full price for a prescription, you will be reimbursed at 80% of the drug cost. Special forms are available in the Plan Office for this purpose.

3. **Mail-Order Service - 90 Day Maximum.** Effective September 1, 2006, Mail-order service is provided through RxAmerica which has contracted with American Diversified Pharmacies ("ADP") mail service facility to provide both a convenience and savings to you.

An order form and patient profile must accompany the first order. Allow 2-3 weeks from the date you mail your order form to delivery to your house. Ask your Physician for a 90-day supply of each medication, plus up to 3 additional refills. Thereafter, each prescription order you receive will include a *Reorder* form.

Co-payments for mail-order prescriptions are 20% for each generic drug prescription and brand named prescription.

For prescription refills, **call RxAmerica's toll-free Customer Service Help Desk at 1-877-889-3402, which operates 24 hrs a day, 7 days a week**. Have your identification and RxAmerica prescription numbers available when you call and identify yourself as a member of IBEW Local 6.

Or, you can use any of these other ordering options listed below:

- Complete the order form, attach a new prescription, include payment information, and mail to:

  American Diversified Pharmacies (ADP)
  P.O. Box 340940
  Sacramento, CA 95834–0940

- Visit ADP on the Internet at: www.adprx.com
- Have your health care provider fax a new prescription to ADP at 1-877-889-3403 (toll-free), along with a cover page containing the following information: Member Identification Number, Patient Name, Patient Date of Birth, and Prescription Delivery Address.

A separate brochure describing the RxAmerica Identification Card and mail-order service programs and a condensed version of the RxAmerica formulary are available in the Plan Office. **A complete listing of participating pharmacies is also available in the Plan Office. To locate the participating pharmacy nearest you, call the toll-free RxAmerica Customer Service Help Desk at 1-877-889-3402.**

4. **Covered Drugs.** Covered drugs include: Federal Legend Drugs (Drugs approved by the FDA requiring a written prescription), Azelex (through age 22), Bee Sting Kits, Depo Provera, Diabetic Test Strips, Lancets and Tablets, Diaphragms, Glucogan, Immunosuppressants, Insulin/Insulin syringes (written prescription), Immunization Drugs, Oral Contraceptives, Injectable drugs (self-administered only), Retin-A (through age 22), Viagra (limit 8 tablets/month), Vitamins (prescription only).

Refer to the exclusions and limitations in V.B.3 and V.B.16 for a description of the type of drugs that are not covered. The Indemnity Plan continues to cover blood and blood plasma, drugs administered at the Physician's office, and injectables that are not self-administered.

Retail: 30 days maximum supply
Mail: 90 days maximum supply

5. **Over-The-Counter Program Options for Proton Pump Inhibitors and Antihistamines -- Prilosec and Claritin.** Effective November 1, 2006, the Plan will cover the full cost of prescription strength Prilosec and Claritin over-the-counter ("OTC") for no copayment, provided you have a prescription. If you purchase these drugs OTC with no prescription the Plan will not cover the costs. This is an optional benefit. **For more information about this benefit, please call the toll-free RxAmerica Customer Service Help Desk at 1-877-889-3402.**

B. DENTAL BENEFITS (APPLICABLE TO ALL MEMBERS AND DEPENDENTS)

1. **Delta Dental Program.** Dental benefits are provided under contract with the Delta Dental Plan ("Delta Dental") to all Active and Retiree members and Dependents. For participants and Dependents eligible for Retiree coverage under the terms of the Plan, the Delta Dental Preferred Option ("DPO") applies as of January 1, 2005. Retirees who choose a DPO dentist will be reimbursed at a higher level than if services were performed elsewhere.

To use this program, members may make an appointment with any dentist of their choice from the Delta Dental list of dentists. All Delta Dental dentists will have Delta Dental treatment forms in their offices and will complete and submit them to Delta Dental for reimbursement. **A complete list of Delta Dental dentists may be obtained by calling (800) 427-2737 or www.deltadentalca.org.**

2. **Schedule of Dental Benefits.** The following is a brief summary of the benefits that are available through this program and is provided for information only.

% of Delta Dental Fee Schedule		(Delta Preferred Option - DPO)	
	Wiremen or Early Retirees (Pre-Age 62)	Motor Shop and Retiree Rates In-Network	Out-of-Network
Diagnostic & Preventive Benefit (oral exams, cleaning, x-rays)	100%	100%	80%
Basic Benefits (Oral Surgery, Restorative treatment, Root Canals, Gum Treatment Ondontics, Periodontics)	80%	80%	80%
Crowns, Jackets & other Cast Restorations	80%	80%	60%
Prosthodontic Benefits (Bridges, Partial Denture, Full Dental)	80%	80%	60%
Annual Maximum:	$4,000	---	---
Orthodontic Benefits:	80%	80%	80%
Maximum Orthodontics	$4,000	$1500	$1500

Delta Group # Active 4874-0005 Delta Group # Active 4874-0006
Delta Group # Retiree 4874-0015 Delta Group # Retiree 4874-0016

The "DeltaPremier" Dental Plan for Actives and their Dependents and the DPO Plan for Retirees and their Dependents are administered by Delta Dental of California. If you have specific questions regarding benefit structure, limitations or exclusions, consult the Evidence of Coverage or contact Delta's Service Department.

3. **Services that are NOT covered by Delta Dental.** Although your Plan covers many of the most commonly needed services, some services are not covered. If you are unsure whether a particular procedure is covered, or how much of it is paid for by your Plan, check with Delta Dental before proceeding.

The following are not covered by Delta Dental:

(a) Services for injuries or conditions that are covered under Workers' Compensation or Employer's Liability Laws;

(b) Cosmetic surgery or dentistry or services to correct congenital malformation;

(c) Experimental procedures;

(d) Therapeutic drugs, premedication or pain relievers;

(e) Hospital costs or extra charges for Hospital treatment;

(f) Anesthesia (except for general anesthesia for oral surgery);

(g) Extra-oral grafts, implants and implant removal;

(h) Treatment related to the Temporomandibular Joint ("TMJ");

C. VISION BENEFITS (APPLICABLE TO ALL MEMBERS AND DEPENDENTS)

Vision benefits, available to all Active and Retiree members and their Dependents, are self-funded and administered by Vision Service Plan, Group #12140808.

1. **Co-Payment and Services Available.** If you use a participating Vision Service Plan ("VSP") provider, you will be responsible for a $10.00 co-payment plus additional payment for certain cosmetic or elective eyewear options. **Benefits include examination and new lenses (for glasses and contacts) every 12 months, and new frames every 24 months.** In addition, the Plan provides a 20% discount on non-covered complete pairs of prescription glasses when provided by a VSP provider. A complete listing of VSP participating providers is available in the Plan Office. You may also contact VSP's customer service at **(800) 877-7195** or you can visit the company's web site at www.vsp.com.

2. **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 will deal directly with VSP for reimbursement for services and materials that are covered by the Plan. You simply pay your providers for the co-payment and any other costs that are not covered.

3. **Out-of-Network Providers.** Although, typically more than 90 percent of patients receive care from VSP 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	$ 40.00
Single Vision Lenses	$ 40.00
Bifocal Lenses	$ 60.00
Trifocal Lenses	$ 80.00
Lenticular Lenses	$125.00
Frame	$ 45.00
Contact Lenses (Medically Necessary)	$210.00
Contact Lenses (Elective)	$105.00

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.

D. MEMBER ASSISTANCE PROGRAM (APPLICABLE TO ALL MEMBERS AND DEPENDENTS)

The Member Assistance Program ("MAP") is a free, confidential counseling and referral service designed to help Plan Participants and their households resolve personal problems that may be interfering with work or home life. This benefit, provided through PacifiCare Behavioral Health Plan ("PBH"), offers a variety of services to Participants.

The available MAP benefits provide a number of valuable resource and referral services, including child and elder care referrals, legal assistance and financial resources for debt management.

If you or a member of your household is facing an unfamiliar and difficult situation or you don't know where to turn -- you may contact PBH. You can talk to a licensed professional in person at no cost. You have up to 3 confidential visits to discuss the situation and develop solutions. The PBH counselor will seek to help you determine what resources you might need or help you or a family member get further treatment. You may access your behavioral health benefits for depression, anxiety, substance abuse or other similar concerns.

The array of resource and referral services offered by PBH include:

$ Child and elder care referrals
$ Personal and workplace stress/conflict resolution
$ Broad-based community referrals
$ Financial resources for debt management
$ Legal resources and referral services
$ Help finding schools and scholarship money for education

Telephone and Online Access:

If you would like to access your MAP benefit from PacifiCare Behavioral Health, you may call 24 hours a day, seven days a week toll free: (877) 225-2267. Furthermore, the PBH website offers a variety of self-help tools and resources to Plan Participants. To access information online, visit www.pbhi.com/labor.

E. CHEMICAL DEPENDENCY TREATMENT BENEFITS (APPLICABLE TO ALL MEMBERS AND DEPENDENTS)

Chemical Dependency Treatment for all levels of care (inpatient, outpatient, partial) is provided through PacifiCare Behavioral Health.

$ $25,000 annual limit
$ $35,000 lifetime limit

F. MENTAL HEALTH (APPLICABLE TO INDEMNITY PLAN AND PACIFICARE MEMBERS AND DEPENDENTS)

Mental Health and Counseling benefits are provided through PacifiCare Behavioral Health as follows:

1. **Mental Health/Counseling.**

   $ Inpatient: 30 days per calendar year
   $ Outpatient: 30 visits with $0 co-payment

2. **Serious Mental Illness.**

   $ Inpatient: Unlimited days covered at 100%
   $ Outpatient: Unlimited visits with $0 co-payment

   A serious mental illness is one of the following:

   (a) Schizophrenia
   (b) Schizoaffective disorder
   (c) Bipolar disorder (manic-depressive illness)
   (d) Major depressive disorder
   (e) Panic disorder
   (f) Obsessive-compulsive disorder
   (g) Pervasive developmental disorder or autism
   (h) Anorexia (nervosaix)
   (i) Bulimia nervosa

Kaiser enrollees will have the MAP combined with Chemical Dependency Treatment benefits described above, but will receive Mental Health services through Kaiser.

Note: All mental health and chemical dependency treatment services provided through this program must be pre-authorized by PacifiCare Behavioral Health by calling 1-877-225-2267. Eligible Participants are required to utilize network facilities and providers for mental health and substance abuse treatment.

G. DEATH BENEFITS (APPLICABLE TO ALL ACTIVE AND PRE-AGE 62 EARLY RETIREE MEMBERS)

In the event you die from any cause while you are covered as an Active member of the Plan (Retiree members age 62 or older are not eligible), your beneficiary will be paid $1,000. If death results from an accident, your beneficiary will be paid an additional $1,000.

1. **Death Benefits.**

Death Benefits are payable only if your death occurs while Active coverage is in force.

(a) Beneficiary Designation. You may name anyone you wish as your beneficiary, and you may change your beneficiary at any time; provided that you complete and file an approved beneficiary form 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 has to be received before your death to be valid.

(b) Extension of Coverage During Periods of Temporary Disability, Direct Self-Payments, Military Service and Family and Medical Leave. Coverage for Death Benefits will be maintained for any period of an extension of eligibility as an Active member coverage as outlined in Section III, *Non-COBRA Continuation of Coverage* beginning on page 21. However, Death Benefits coverage will not be extended during any periods for which health care benefits are extended solely on account of COBRA. In addition, if you are a Group I Early Retiree your Death Benefits coverage will be extended until you become eligible for coverage as a full Retiree under the Plan at age 62. Your Death Benefits coverage shall terminate at the same time that your eligibility for Active coverage terminates. If you are ordered to active military service under USERRA, you continue to be covered for these Death Benefits.

2. **Death Benefits are Not Insured.** The Death Benefits described herein are not insured. Rather, benefits are payable only from the assets of the Plan. Consequently, Death Benefits are payable only to the extent that there are Plan assets to pay such benefits.

3. **Termination of Death Coverage.** Termination of eligibility for Death benefits shall occur for any reason set forth in III.E, above. In addition, coverage will terminate upon the date a member is eligible for coverage as a Retiree under the terms of the Plan.

4. **Death Benefits Apply Only to Active Members.** Coverage under this subsection is afforded only to the Active member. Dependents of an eligible Active member are not eligible for Death benefits.

SECTION VIII: LONG TERM DISABILITY BENEFITS

A. ELIGIBILITY

You will be eligible for Long Term Disability Benefits ("Disability Benefits") under this Plan if you meet the following requirements:

1. **36 Months Continuous Covered Employment Requirement.** You have been continuously employed in Covered Employment for at least thirty-six (36) months immediately preceding your disability.

For purposes of satisfying the thirty-six (36) months of continuous employment required in this paragraph, Covered Employment shall include periods of actual employment for a Contributing Employer and registration on an IBEW Local 6 referral list.

2. **Contribution Hours Requirement.** You have worked in Covered Employment for which contributions are required to be made on your behalf by your Employer for:

(a) 250 hours during the 3 months (including any partial month if it is to your advantage) immediately preceding disability; or

(b) 500 hours during the 6 months (including any partial month if it is to your advantage) immediately preceding disability; or

(c) 750 hours during the 9 months (including any partial month if it is to your advantage) immediately preceding disability; or

(d) 1000 hours during the 12 months (including any partial month if it is to your advantage) immediately preceding disability.

For purposes of satisfying the hours of employment required in this paragraph, contribution hours include only actual hours worked under an IBEW Local 6 Collective Bargaining Agreement or subscription agreement which requires contributions to be made to this Plan by your Employer.

3. **Notice & Filing Requirements.** Effective January 1, 2005, in order to be eligible for Disability Benefits, you must notify the Plan Office and submit written proof of your disability(ies) no later than the later of: (1) 90 days after the end of the Waiting Period or (2) the date your hour bank reserve account is exhausted. See VIII.F.5 for a description of "Waiting Period."

B. APPRENTICE ELIGIBILITY RULE

If you become totally disabled as an Apprentice, you may qualify for benefits if:

1. You began your Covered Employment in the electrical industry less than 36 months prior to your disability; and

2. You have been continuously employed under the definition of Covered

Employment since you began work as an Apprentice.

C. LIMITED BENEFITS RULE

In the event you do not meet the requirements in A.1, you will qualify for Limited Benefits if you have satisfied the Contribution Hours requirement in A.2 above. Benefits will be limited to a maximum of one month of benefits for each calendar month in which at least 120 hours of Employer contributions were made on your behalf within the last thirty-six (36) month period immediately preceding your disability. In no circumstances, however, will benefits exceed the total of said months of eligibility earned in said thirty-six (36) month period. One (1) month of benefits eligibility will be cancelled for each month you receive benefits from the Plan. Regardless of the number of separate periods of disability that may occur, no month of eligibility for benefits pursuant to this rule may support a benefit payment more than once.

D. PROOF OF TOTAL DISABILITY; DEFINITION

1. **The First 12 Months of Benefits.** In order to qualify for benefits during the first 12 months of your disability, you must be considered "totally disabled" if you are unable, solely because of Illness, disease, or Injury, to work at your own job.

To be considered totally disabled, you must be under the care of an acceptable medical treatment source*. The proof required prior to receipt of Disability Benefits for the first 12 months of your disability is an *Attending Physician's Statement* form, which is available at the Plan Office and which must be completed and submitted by your Physician to the Plan Office.

Proof from your attending Physician(s) that you continue to be totally disabled may be required at reasonable intervals by the Plan. The Board of Trustees 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 licensed Physician (designated and paid by the Plan), you will no longer be considered totally disabled and will lose your Disability Benefits.

*Acceptable medical treatment sources are:

(a) Licensed Physician,
(b) Licensed osteopaths,
(c) Licensed or certified psychologists,
(d) Licensed optometrists for the measurement of visual acuity and visual fields.

2. **After 12 Months of Benefits.** In order to qualify for benefits beyond the first 12 months of your disability, you must have received a disability award from the Social Security Administration ("SSA") and have filed a copy of this award with the Plan Office.

(a) Exception. If you have satisfied all of the SSA's requirements for receiving a disability award, but have been denied such award *solely because you lacked a sufficient number of Social Security Quarters of Coverage*, you will be deemed to have met the above qualification for purposes of receiving a benefit under the Plan.

(b) 6-Month Benefit Extension. If you are still disabled after 12 months and

have applied for but not yet received a Social Security disability award, you may apply for a six (6) month extension of benefits as described more fully in F.2, below.

Note: Since the process of applying for a Social Security disability award can often take up to a year or longer, if you feel you might need benefits beyond 12 months, you are strongly encouraged to begin the process of applying for a Social Security disability award as early in your disability as possible.

E. SUCCESSIVE DISABILITIES

Successive periods of disability will be considered as one period of disability if they arise from:

1. the same or related causes and are separated by less than 3 months of continuous active employment with a Contributing Employer; or

2. different and unrelated causes and are not separated by return to active employment with a Contributing Employer, provided that the successive periods of disability *commence* while you are working in Covered Employment or while you are receiving income benefits from the Plan.

In the event eligibility for benefits is established pursuant to the *Limited Benefits Rule* in subsection C, above, benefits may be paid only for the number of months of limited eligibility regardless of whether successive disabilities are considered one period or separate periods of disability.

Only one Waiting Period (see F.5, below) will be required with respect to successive periods of disability, which are considered as one period of disability.

F. DISABILITY BENEFIT -- AMOUNT PAYABLE; WAITING PERIOD

The Disability Benefit consists of a monthly income as described in the following paragraphs. Benefits will commence on the first day following your completion of the Waiting Period (see paragraph 5, below) with the first Disability Benefit check being paid at the end of the month in which the Waiting Period is satisfied. The continuance of Disability Benefits is subject to satisfaction of the above requirements, including periodic satisfaction of continued total disability by way of Physician examinations.

1. **The First 12 Months of Benefits.** Four hundred dollars ($400) per month without offset from any other source of income. Payments are subject to FICA taxes.

2. **Extension of Benefits.** If you are still disabled at the conclusion of the initial 12 months of benefits, you may qualify for an extension of the original 12-month benefit period. This extension can only be granted by having your Physician send a completed *Application For Extended Long Term Disability Benefits* form to the Plan Office. This extension of benefits cannot exceed 6 months and is generally granted when, at the conclusion of the initial 12-month benefit period:

(a) your Physician believes you will be able to return to work within 6 months, or

(b) you are waiting for determination from the Social Security Administration concerning a disability award application, or

(c) it is not clear how much longer your disability will last. For example, your Physician may not be able to determine the expected duration of the disability until sufficient time has passed after surgery to analyze the success of the operation. Under such circumstances, an extension may be granted to allow sufficient time (up to 6 months) to determine if you can return to work.

3. **After 12 Months of Benefits (The 13th month and thereafter).** Four hundred dollars ($400) per month *only if you have been awarded or are receiving disability benefits under a Social Security Administration disability award.*

Commencing with the 13th month, and as long as you are totally disabled, the $400 per month benefit will not be reduced, regardless of any other income benefit you may be receiving at the time, except as provided in the *Termination of Benefits* (VI.F) and definition of "Total Disability".

4. **Pension Benefits-Contribution to Pension Plan.** Thirty-one dollars and twenty-five cents ($31.25) per month (or the appropriate prorated amount in the case of disability periods of less than one month) shall be paid to the Northern California Electrical Workers Pension Plan. If and when you begin drawing a pension from a participating Local Union, the $31.25 pension benefit will be terminated.

5. **Waiting Period.** You must be continuously totally disabled for a period of 30 days before benefits are payable. Total disability will not be deemed to have commenced more than 3 days prior to the first visit of (or to) a licensed Physician for diagnosis or treatment of the disabling condition. Total disability will not be deemed to have commenced until after you have stopped working as a result of the disabling condition.

G. TERMINATION OF BENEFITS

1. **Disabilities Before Age 60.** If disabilities occur at or before age 60, Disability Benefits shall cease upon the earliest of the following events:

(a) recovery; or
(b) death; or
(c) attainment of age 65; or
(d) at retirement effective on or after January 1, 2003 under an Electrical Workers (IBEW) Pension Plan.

2. **Disability After Age 60 or Older**. For disabilities, which occur after age 60, Disability Benefits *shall cease upon the earliest of the following events*:

(a) after 5 years of benefit payments; or
(b) at recovery; or
(c) upon death; or
(d) attainment of age 70; or
(e) at retirement under an Electrical Workers (IBEW) Pension Plan which

becomes effective on or after January 1, 2003.

H. EXCLUSIONS

Certain disabilities do not qualify for coverage for Disability Benefits under this Plan. Therefore, you will not receive benefits for disabilities caused by any one of the following:

1. Intentionally self-inflicted injuries, provided that the injuries are either (a) not otherwise covered by the Plan or (b) not the result of a medical condition, such as depression;

2. Your commission of, or your participation in, a felony; and/or
3. An act of war (whether declared or not), insurrection, rebellion, or participation in a riot or civil commotion.

I. 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 benefits payable to the recipient unless the Board of Trustees concludes that requiring such repayment would be inequitable under the circumstances of the case.

SECTION IX: CLAIMS FILING AND APPEAL PROCEDURES

The claims filing and appeals procedures described below will apply to claims and appeals over which the Board of Trustees has discretion, solely for benefits covered under the Indemnity Plan. Generally, except for questions of eligibility under the Plan, the Board of Trustees does not have any say over benefit determinations made by an HMO or other provider or insurance carrier. Claims for benefits under such arrangements must be pursued using the claims and appeals procedures provided by such HMO, provider or insurance carrier. **In other words, DO NOT USE THE SAN FRANCISCO ELECTRICAL WORKERS HEALTH AND WELFARE PLAN'S CLAIMS FILING AND APPEALS PROCEDURE for benefit determinations made by Kaiser, PacifiCare, Secure Horizon, Delta Dental, VSP or PacifiCare Behavioral Health claims. Instead, for HMO, Dental or Vision claims, please refer to the claims procedures in the Supplemental Summaries of those programs available in the Plan Office.**

IMPORTANT NOTE: In all cases, provisions under the HMO provider and the Indemnity Plan procedures require that claims for benefits or reimbursement for medical services and appeals from the denial of claims must be submitted within a specific period of time. A failure to meet these time limits may bar the claim or appeal. Study the following and the enclosed brochures for additional details regarding the making of a claim or the taking of an appeal.

A. HOW TO FILE A CLAIM

Claims are paid in accordance with bills and forms supplied by Hospitals and attending Physicians. A Claim shall be considered to have been filed as soon as it is received by the Plan Office provided it is substantially complete, with all necessary documentation. If the form is not substantially complete, or if required documentation has not been furnished, the claimant will be notified as soon as reasonably possible of what information or documentation is necessary to complete the Claim. Claims must be filed within 24 months from the date of treatment. (See B.2 for definition of "Claim".)

Have your Physician forward Claims directly to the Plan Office, 720 Market Street, Suite 700, San Francisco, CA 94102-2509; (415) 263-3670.

Medicare-eligible Retirees and their Medicare-eligible Dependents should have their Hospital and Physicians submit claims to Medicare first. After Medicare has made a payment, a copy of the *Medicare Explanation of Benefits Worksheet* should then be submitted with a Claim to the Plan Office for processing.

B. CLAIMS AND APPEALS PROCEDURES B DEFINITIONS

1. **Adverse Benefit Determination.** An "Adverse Benefit Determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Each of the following is an example of an Adverse Benefit Determination:

(a) a payment of less than 100% of a Claim for benefits (including coinsurance or co-payment amounts of less than 100% and amounts applied to the deductible);

(b) a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;

(c) a failure to cover an item or service because the Plan considers it to be Experimental, Investigational, not Medically Necessary;

(d) a restriction on reimbursement for particular services because they are classified as related to a mental or nervous, rather than a physical, condition; and

(e) a decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan.

Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the Participant pays the entire cost, is not considered an Adverse Benefit Determination (but only to the extent that the pharmacy's decision for denying the prescription is based on coverage rules predetermined by the Plan).

2. **Claim.** The term "Claim" means a request for a benefit made by a Participant in accordance with the Plan's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a Participant files a Claim for specific benefits, and the Claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a Claim.

The presentation of a prescription order at a pharmacy does not constitute a Claim, to the extent benefits are determined based on cost and coverage rules predetermined by the Plan. If a Physician, Hospital or pharmacy declines to render services or refuses to fill a prescription unless the Participant pays the entire cost, the Participant should submit a Post-Service Claim for the services or prescription, as described under these procedures below.

A request for pre-certification or prior authorization of a benefit that does not require pre-certification or prior authorization by the Plan is not considered a Claim. However, requests for pre-certification or prior authorization of a benefit where the Plan does require pre-certification or prior authorization are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under Claim Procedures, below.

Claims are Categorized as Follows:

(a) Urgent Claim. The term "Urgent Claim" means a Claim for medical care or treatment that:

(i) if normal Pre-Service Claim standards for rendering a decision were applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(ii) in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that

could not be adequately managed without the care or treatment that is the subject of the Claim.

(b) Pre-Service Claim. The term "Pre-Service Claim" means a Claim for a benefit for which the Plan requires pre-certification or prior authorization before medical care is obtained in order to receive the maximum benefits allowed under the Plan.

(c) Concurrent Claim. The term "Concurrent Claim" means a Claim that is reconsidered after an initial approval has been made which results in a reduction, termination or extension of the previously approved benefit.

(d) Post-Service Claim. The term "Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Urgent or Concurrent Claim. This will generally be a claim for reimbursement for services already rendered.

(e) Disability Claim. The term "Disability Claim" means any Claim that requires a finding of total disability as a condition of eligibility.

3. **Relevant Documents.** "Relevant Documents" include documents pertaining to a Claim if they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the regulations, or constitute the Plan's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Plan's rules were appropriately applied to a Claim.

C. NOTICE OF CLAIM DENIAL

If a claim is wholly or partially denied, the claimant shall receive a written notice of denial as follows:

1. **Contents of Notice.** The notice of denial shall contain the following, written in a manner calculated to be understood by the claimant:

(a) the specific reason or reasons for the denial;
(b) specific reference to pertinent Plan provisions on which the denial is based;
(c) 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; and
(d) appropriate information as to the steps to be taken if the claimant wishes to submit the claim for review.

2. **Time of Notice.** To assure that you are eligible for medical or Hospital benefits, you should call or have your Physician /Hospital call the Plan Office at (415) 263-3670 to pre-certify your eligibility for benefits. In the event that you do not obtain pre-certification and the Plan Office determines that a Claim is not covered for any reason, you will be notified of a Claim denial:

(a) Urgent Care Claims. In the event the claim involves "Urgent Care", which is

defined above in B.2(a)(i), you will be notified within twenty-four (24) hours of the submission of the Claim, if the information necessary to process the claim is incomplete, and/or within seventy-two (72) hours of receipt of the Claim by the Plan Office in the event coverage is denied.

(b) Pre-Service Claims. A Pre-Service Claim is a Claim for a benefit for which the Plan requires pre-certification or prior authorization before medical care is obtained as a condition of receiving maximum benefits allowed under the Plan. Under the terms of this Plan, claimants are not required to obtain pre-certification for any services.

(c) Concurrent Claims. Any request by a Participant to extend an approved Urgent Claim will be acted upon by the Plan within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to continue a plan of treatment that is in progress that does not involve an Urgent Claim will be decided in enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated. (See C.3, below for a description of Appeal Procedures.)

(d) Post-Service Claims. A Post-Service Claim must be submitted to the Plan Office in writing, using an appropriate claim form (which may be obtained by contacting the Plan Office), as soon as possible after expenses are incurred. Failure to file a Post-Service Claim within the time required will not invalidate or reduce any Claim if it was not reasonably possible to file the Claim within such time. In that case, however, the Claim must be submitted electronically and/or as soon as reasonably possible, but in no event later than one year from the date the charges were incurred.

The Claim form must be completed in full and an itemized bill(s) must be attached to the claim form in order for the request for benefits to be considered a Claim. The Claim form and/or itemized bill(s) must include all information required by the Plan Office as indicated on the form.

A Post-Service Claim is considered to have been filed upon receipt of the Claim by the Plan Office. Ordinarily, claimants will be notified of decisions on Post-Service Claims within 30 days from the receipt of the Claim by the Plan Office. The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the claimant will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is required because the Plan needs additional information from the claimant, the Plan will issue a *Request for Additional Information* that specifies the information needed. The claimant will have 45 days from receipt of this form. During the 45-day period in which the claimant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the *Request for Additional Information* form is issued until either 45 days or until the date the claimant responds to the request for information, whichever is earlier. The Plan then has 15 days to make a decision on the Claim and notify the claimant of the determination.

If the Plan determines that additional information is required from the claimant, and the claimant fails to provide any requested information within 45 days, the Claim will be denied and the Plan will issue a Notice of Adverse Benefit Determination.

(e) Disability Claims. A Disability Claim must be submitted to the Plan Office within 90 days after the date of the onset of the disability. The Plan will make a decision on the Disability Claim and notify the claimant of the decision within 45 days after receipt of the Claim by the Plan Office. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan Office will notify the claimant of the reason for the delay and the date by which the Plan expects to render a decision. This notification will occur before the expiration of the initial 45-day period. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the Claim, and the additional information needed to resolve those issues.

A decision will be made within 30 days of the date the Plan notifies the claimant of the delay. The period for making a decision may be delayed an additional 30 days, provided the Plan notifies the claimant prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from the Participant, the extension notice will specify the information needed. If the information is not provided within the 45-day period, the Claim will be denied. During the 45-day period in which the Participant is allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The period for making the determination is suspended from the date of the extension notice until the earlier of: (1) 45 days from the date of the notification; or (2) the date the claimant responds to the request. Once the claimant responds to the Plan's request for the information, the claimant will be notified of the Plan's decision on the Claim within 30 days from the date of receipt of the information by the Plan Office.

For Disability Claims, the Plan reserves the right to have a Physician examine the claimant (at the Plan's expense) as often as is reasonable while a Claim for benefits is pending.

(f) Authorized Representatives. An authorized representative, such as a spouse, Domestic Partner or an adult child, may submit a Claim or appeal on behalf of a claimant if the claimant has previously designated the individual to act on his or her behalf. An *Appointment of Authorized Representative* form, which may be obtained from the Plan Office, must be used to designate an authorized representative. The Plan Office may request additional information to verify that the designated person is authorized to act on the claimant's behalf.

A health care professional with knowledge of the claimant's medical condition may act as an authorized representative in connection with an Urgent Claim without the claimant's having to complete the *Appointment of Authorized Representative* form.

(g) Notice of Initial Benefit Determination. The claimant will be provided with written notice of the initial benefit determination. If the determination is an Adverse Benefit Determination, the notice will include:

(i) the specific reason(s) for the determination;
(ii) reference to the specific Plan provision(s) on which the determination is based;
(iii) a description of any additional material or information necessary to perfect the Claim, and an explanation of why the material or

information is necessary;

(iv) a description of the Plan's appeal procedures and applicable time limits;

(v) a statement of the Participant's right to bring a civil action under ERISA Section 502(a) following the appeal of an Adverse Benefit Determination;

(vi) if an internal rule, guideline or protocol was relied upon in deciding the Claim, a statement that a copy of such rule, guideline or protocol is available upon request at no charge;

(vii) if the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge; and

(viii) for Urgent Claims, a description of the expedited review process applicable to Urgent Claims (for Urgent Claims, the notice may be provided orally and followed with written notification).

3. **Appeal Procedures.**

(a) Appealing an Adverse Benefit Determination. If a Claim is denied in whole or in part, or if the Participant disagrees with the decision made on a Claim, the claimant may appeal the decision. Appeals must be made in writing and must be submitted to the Plan Office within 180 days after the claimant receives the Notice of Adverse Benefit Determination.

(i) Urgent Claims. Appeals of Adverse Benefit Determinations regarding Urgent Claims must be made within 180 days after receipt of the Notice of Adverse Benefit Determination by either:

(I) Calling the Plan Office and asking to speak to the Utilization Review Representative. All oral requests must be followed by a faxed written request within 24 hours.

(II) Faxing the request to the attention of the Utilization Review Representative.

NOTE: Appeals of Urgent Claims may not be submitted via the US Postal Service.

(ii) Concurrent Claims. Appeals of Adverse Benefit Determinations regarding Concurrent Claims must be made in the same manner described for Urgent Claims.

(iii) Post-Service Claims and Disability Claims. The appeal of a Post-Service Claim or Disability Claim must be submitted in writing to the Plan Office within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:

(I) the patient's name and address
(II) the claimant's name and address, if different;
(III) a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;
(IV) the date of the Adverse Benefit Determination; and
(V) the basis of the appeal, i.e., the reason(s) why the Claim should not be denied.

(b) The Appeal Process. The claimant will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination. The claimant will be provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his or her Claim.

A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the claimant.

If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Investigational or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, the claimant will be provided with the identification of medical or vocational experts, if any, that gave advice on the Claim, without regard to whether the advice was relied upon in deciding the Claim.

(c) Time Frames for Sending Notices of Appeal Determinations.

(i) Urgent Claims. Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by the Plan Office.

(ii) Concurrent Claims. Notice of the appeal determination for a Concurrent Claim that involves an extension of an Urgent Care Claim will be sent by the Plan within 72 hours of receipt of an appeal by the Plan Office.

(iii) Post-Service Claims and Disability Claims. Ordinarily, decisions on appeals involving Post Service Claims and Disability Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of claimant's request for review. However, if the request for review is received at the Plan Office within 30 days before the next regularly scheduled meeting, the request for review may be considered at the second regularly scheduled meeting following receipt of the claimant's request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the claimant's request for review may be necessary. The Participant will be advised in writing in advance if this extension will be necessary.

Once a decision on review of claimant's Claim has been reached, the claimant will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

(iv) If the decision on review is not furnished to the claimant within the time specified in this subparagraph (c), the Claim shall be deemed denied upon review. The claimant shall be free to bring an action upon his or her Claim in accordance with subparagraph (e), below.

(d) Content of Appeal Determination Notices. The determination of an appeal will be provided to the claimant in writing. The notice of a denial of an appeal will include:

(i) the specific reason(s) for the determination;

(ii) reference to the specific Plan provision(s) on which the determination is based;

(iii) a statement that the claimant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;

(iv) a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;

(v) if an internal rule, guideline or protocol was relied upon, a statement that a copy of such rule, guideline or protocol is available upon request at no charge; and

(vi) if the determination was based on Medical, Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

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

No lawsuit may be commenced more than 2 years after the end of the year in which medical or dental services were provided or a benefit was denied or other action, omission or rule affected your situation or, if the Claim is for Long Term Disability Benefits, more than 2 years after the onset of the disability.

The provisions of this subparagraph shall apply to and include any and every claim to benefits from

the Plan, and any Claim or right asserted under the Plan or against the Plan, regardless of the basis asserted for the Claim, and regardless of when the act or omission upon which the Claim is based occurred, and regardless of whether or not the claimant is a "Participant" or "beneficiary" of the Plan with the meaning of those terms as defined in ERISA. Such Claim shall be limited to benefits due to him or her under the terms of the Plan, or to clarify his or her rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive.

SECTION X: GENERAL PROVISIONS

A. CONSTRUCTION

The validity of the Plan or any of its provisions will be determined under and will be construed according to ERISA and other federal laws and, to the extent permissible, according to the laws of the State of California. This 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.

B. NO VESTED RIGHT

Nothing in this Plan shall be construed as giving Employees, retired or terminated, Dependents or any other person a vested right to continued coverage under this Plan. The Board of Trustees may require new or greater co-payments and/or may change the eligibility requirements and any other Plan rules at any time.

C. 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.

D. AVAILABLE ASSETS FOR BENEFITS

Benefits provided by this Plan can be paid only to the extent that the Plan has available adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to such payments. No Contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder beyond the obligation of the Contributing Employer to make contributions as required in an IBEW Local 6 Collective Bargaining Agreement.

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

E. INCOMPETENCE OR INCAPACITY

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

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

F. GENDER AND NUMBER

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

SECTION XI: POTENTIAL LOSS OF BENEFITS

You or your beneficiary could lose your benefits or have payments delayed in at least the following circumstances:

A. INADEQUATE OR IMPROPER EVIDENCE

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

B. PROHIBITED EMPLOYMENT IN THE ELECTRICAL INDUSTRY

If after your retirement you engage in certain kinds of work in the electrical industry, known as "Prohibited Employment", your entitlement to Retiree health care benefits may be suspended.

C. FAILURE TO FILE COMPLETE ENROLLMENT CARDS FOR YOURSELF OR YOUR DEPENDENTS

No benefits are payable until you and/or your Dependent(s) are properly and timely enrolled in the Plan.

D. INCOMPLETE INFORMATION/FALSE STATEMENTS

If you fail to provide requested information or give false information to verify disability, age, beneficiary information, marital status or other vital information, payment of your pension may be postponed.

E. THIRD PARTY AT FAULT/SUBROGATION CLAIMS

The Plan has the right to recover any amounts paid by the Plan for claims for which you received a distribution pursuant to a court judgment, settlement agreement, insurance payment or any other form of payments from a third party. This includes any payments you receive from your own insurance company.

F. WORK-RELATED INJURIES

The Plan is not responsible for paying any claims incurred as a result of a work-related injury. This is so even though you have not filed a claim with workers compensation.

G. RIGHT TO RECOVER CLAIMS PAID OR OFFSET FUTURE CLAIMS

The Plan has the right to recover any amounts improperly paid as provided in subsections D and E above or otherwise or any other payments made by the Plan which were improper or should not have been paid. The Plan may offset any amounts owed to the Plan against any claims that you and/or a Dependent incur in the future.

H. PLAN EXCLUSIONS

The Plan and any HMO or PPO contain exclusions and exceptions for coverage. You should be aware of the Plan's limitations, exclusions, co-payments and other facets of the Plan in which you may not receive full payment on a claim or reimbursement.

If you make a false statement to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, you will be liable to the Plan for any benefits paid in reliance on such false statements or information, and any attorney fees and costs incurred in effecting recovery or which were incurred as a result of the false statement or information. This includes but is not limited to costs incurred by the Plan Office, reasonable attorney fees, and interest charges. The Plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

I. PLAN TERMINATION

If the Plan terminates, benefits may no longer be provided.

SECTION XII: PLAN INFORMATION

A. NAME OF PLAN

The name of this Plan is the San Francisco Electrical Workers Health and Welfare Plan.

B. TYPE OF PLAN

This is a health care plan, providing the following kinds of benefits: Medical, Prescription Drugs, Disability, Dental, Vision, Death and Accidental Death & Dismemberment Benefits.

C. PLAN ADMINISTRATOR

The official Plan Administrator is the Joint Board of Trustees, half of whom are Union representatives and half of whom are Employer representatives. Its address and telephone number follow:

San Francisco Electrical Workers Health & Welfare Trust
Telephone: (415) 263-3670
IRS Employer identification No.: 94-6061762
Plan No.: 501

The names and business addresses of the Trustees are:

John O'Rourke IBEW Local Union #6 55 Fillmore St. San Francisco, CA 94117	Thomas Coleman S.F. Elec. Contractors Assn. 555 Gough St. San Francisco, CA 94102
Terrence McKenna IBEW Local Union #6 55 Fillmore St. San Francisco, CA 94117	Leonard Lynch Edwards Scott Electric 555 Gough St. San Francisco, CA 94102
Kevin Hughes IBEW Local Union #6 55 Fillmore St. San Francisco, CA 94117	Jim Reed Century Electric 555 Gough St. San Francisco, CA 94102
Alternate: Jeff Hawthorne IBEW Local Union #6 55 Fillmore St. San Francisco, CA 94117	Alternate: Ernest Ulibarri Barri Electric 555 Gough St. San Francisco, CA 94102

D. TYPE OF ADMINISTRATION

The Plan Administrator is the Joint Board of Trustees. The Board has contracted with the Electrical Industry Service Bureau, Inc. ("EISB"), to serve as Plan Manager.

E. LEGAL PROCESS

Legal process may be served on the Joint Board of Trustees care of Judith Fisher, EISB, Inc., 720 Market Street, Suite 700, San Francisco, CA 94102-2509.

F. ORGANIZATIONS THAT RECEIVE PREMIUMS

The following organizations receive premiums from the Plan to provide all Plan benefits:

1. Union Labor Life Insurance Co. (Stop Loss Coverage-Indemnity Plan)
2. PacifiCare of California (HMO)
3. Kaiser Foundation Health Plan, Inc. (HMO)
4. First Health Group Corp. (PPO-Network-Indemnity Plan)
5. First Health Group Corp. (Clinical Management Services-Indemnity Plan)
6. First Health Group Corp. (Transplant Network-Indemnity Plan)
7. Delta Dental Plan- All Plans
8. Vision Service Plan (VSP)- All Plans
9. RxAmerica (Indemnity Prescription Drugs)
10. PacifiCare Behavioral Health (Mental Health-Indemnity/PacifiCare Substance Abuse Treatment- All Plans)

G. METHOD OF FUNDING

Contributions to provide Plan benefits are paid by the sponsoring Employers in accordance with the Trust Agreement. In some cases, as described in this booklet, members may be able to self-pay for periods of time when they are not covered by Employer contributions.

H. CLAIM AND APPEAL PROCEDURES

The procedures for filing claims and appealing claim denials are set forth beginning on page 65 of this booklet.

I. FISCAL YEAR (PLAN YEAR)

The fiscal year of the Plan is the twelve-month period ending each January 31st, and the Plan's records are maintained on that basis. This is also known as the "Plan Year."

SECTION XIII: STATEMENT OF ERISA RIGHTS

A. YOUR RIGHTS UNDER ERISA

As a Participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Office and at other specified locations such as work sites and the Union office, documents governing the Plan, including Collective Bargaining Agreements 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. Pursuant to ERISA, the Plan Office may require that you pay a reasonable charge for the copies; and

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, spouse or 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 summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

6. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan and when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if 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.

B. PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in your interest and the interest of other Plan Participants and beneficiaries. No one, including your Employer, your Union, 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.

C. ENFORCING YOUR RIGHTS

If your Claim for a Plan benefit is denied in whole or in part, you have a right to know why this was done, 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 the above 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 Plan Administrator or the Plan Administrator'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 booklet, 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 it should happen that 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.

D. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your 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 1-800-998-7542 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.

SECTION XIV: DEFINITIONS

These are some of the terms used in your booklet. Some other terms are described where they are used. PLEASE READ THEM CAREFULLY. They can help you to better understand what your benefits are.

Board means the Board of Trustees established by the Trust Agreement.

Calendar year means the twelve-month period beginning January 1 and ending December 31.

Convalescent Hospital or **Skilled Nursing Facility** means an institution which:

1. is regularly engaged in providing skilled nursing care for sick and injured persons under 24-hour supervision of a Physician or a graduate Registered Nurse (R.N.);

2. has available at all times the services of a Physician who is a staff member of a general Hospital;

3. has on duty 24 hours a day a graduate Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or skilled practical nurse;

4. has a graduate Registered Nurse (R.N.) on duty at least 7 hours per day;

5. maintains a daily medical record for each patient; and

6. complies with all licensing and other legal requirements.

Convalescent Hospital does **not** mean any institution, or part thereof (other than incidentally), which is a place for rest, a place for Custodial Care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or a similar institution.

Covered Charge(s) or Covered Expense(s) means only those charges which are Reasonable and Customary and which are incurred as a result of a Medical Necessity for conditions that are covered under this Plan. It shall also mean only those charges incurred by a Covered Person while eligible for benefits under this Plan.

Covered Employee or Employee means a member performing work under a Collective Bargaining Agreement with IBEW Local 6 which requires contributions to this Plan, or an employee for whom contributions are made to this Plan pursuant to a subscription agreement approved by the Board of Trustees.

Covered Employment means work performed under a Collective Bargaining Agreement with a Local Union of IBEW which requires contributions to this Plan.

Covered Person or Participant means each eligible Employee or Retiree and each of his or her Dependents, if any.

Custodial Care means treatment, services or confinement which 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. Custodial Care includes personal care, homemaking services, moving the patient, acting as companion or sitter, or supervising medication which can usually be self-administered.

Employer or Contributing Employer means an employer who makes contributions to this Plan on behalf of Covered Employees.

Experimental or Investigational Measures mean any treatment or service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of medicine, as determined by the Plan's medical review department and/or an independent medical reviewer.

Generally Accepted means treatment or service that:

1. 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; and

2. is in general use in the medical community; and

3. is not under continued scientific testing or research as a therapy for the particular injury or sickness which is the subject of claim.

Hospital means an institution which:

1. is primarily engaged in providing, by or under the supervision of Physicians, inpatient diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or rehabilitation of injured, disabled or sick persons;

2. maintains clinical records on all patients;

3. has bylaws in effect with respect to its staff of Physicians;

4. has a requirement that every patient be under the care of a Physician;

5. provides 24-hour nursing service rendered or supervised by a registered professional nurse;

6. has in effect a Hospital utilization review plan;

7. is licensed pursuant to any state or agency of the state responsible for licensing Hospitals; and

8. has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

The term "Hospital" does not include an institution, or that part of an institution, used mainly for: (1) nursing care; (2) rest care; (3) convalescent care; (4) care of the aged; (5) Custodial Care; or (6) educational services.

Illness means a bodily disorder, infection, or disease and 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.

Medically Necessary the treatment must be ordered by a Physician or other Licensed or Certified Health Care Provider to diagnose or treat an Injury or Illness and be:

1. generally recognized as effective and essential to the treatment of the Injury or Illness for which it is ordered;

2. appropriate for the symptoms and consistent with the diagnosis;

3. the appropriate level of care, and which:

(a) is provided in the most appropriate setting, based on the diagnosis and condition;

(b) could not have been omitted without an adverse effect on the Covered Person's condition or the quality of medical care; and

(c) based on generally recognized and accepted standards of medical practice in the United States;

(i) is not considered Experimental, Investigatory, or primarily limited to research in its application to the Injury or Illness;

(ii) is not primarily for scholastic, educational, vocational or developmental training;

(iii) not primarily for the conform, convenience or administrative ease of the Physician or other health care provider, or the member or his or her family or care taker; and

(iv) is not Custodial Care.

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

Other Licensed or Certified Health Care Provider means Physician's assistant, nurse practitioners or midwife, or nurse midwife, who provides medical care within the scope of his or her license or certificate.

Physician means a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) authorized to perform medical or surgical service within the lawful scope of his or her practice, and shall also include any other health care provider or allied practitioner as mandated by State Law.

Plan. The term "**Plan**" is used interchangeably with the term "Trust Fund" throughout this document and means the San Francisco Electrical Workers Health & Welfare Trust.

Plan Office means the administrative office of the San Francisco Electrical Workers Health & Welfare Plan in San Francisco, California.

Prescription Drugs means any article that may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act including any amendments thereto, only upon a written or oral prescription of a Physician or Dentist licensed by law to administer it.

Reasonable and Customary means the charges which fall 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 of Trustees. The term "region" means a county or such greater area that is necessary to obtain a representative cross-section of the usual charges made. Currently the Plan uses Medical Data Research ("MDR") at the 90th percentile to determine what is Reasonable and Customary. This means that the acceptable limit will not exceed the amounts normally charged by 90% of the Physicians in a geographical area.

Trust Agreement means the Trust Agreement establishing the San Francisco Electrical Workers Health & Welfare Plan and any modification, amendment, extension or renewal thereof.

Union means the International Brotherhood of Electrical Workers, Local 6 that has entered into a Collective Bargaining Agreement with an Employer, the terms of which require such Employer to make contributions to the San Francisco Electrical Workers Health and Welfare Plan on behalf of eligible Employees, Retirees and their Dependents.

For Further Information Call or Write:

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE TRUST

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San Francisco, CA 94102-2509
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