SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN
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Summary of Material Modification

NOTICE TO ALL PARTICIPANTS REGARDING CHANGES TO THE SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN

The Board of Trustees of the San Francisco Electrical Workers (SFEW) Health & Welfare Plan has approved the following changes to the SFEW Health & Welfare Plan (Plan).

1. ELIGIBILITY & ENROLLMENT RULES

Effective October 1, 2010, the following changes relating to Plan eligibility and enrollment were made.

A. Updated Enrollment Information Time Period Requirement and Possible Suspension of Coverage

As before, if you have a family member who is no longer a Dependent, you are required to notify the Plan Office that the individual is no longer your Dependent under the terms of the Plan. You must also provide the Plan Office with updated enrollment information when requested. If you fail to provide requested enrollment information to the Plan Office **within 60 days of the request**, you and/or your Dependent's eligibility for Plan coverage may be suspended.

B. Additional Dependent Enrollment Periods

If you have a family member who qualifies as a Dependent under the Plan, you have limited opportunities to enroll your Dependent in the Plan: (1) when you first enroll for coverage; (2) during open enrollment periods (which usually occur during the month of July with changes effective August 1st); (3) within 30 days of when they first become eligible under the Plan as a result of marriage, domestic partner registration, birth or adoption of a child, or enrollment of your Dependent as an age 19 through 24 full-time student, or as an age 19 through 25 adult child.

If your coverage lapses during open enrollment and you re-establish your eligibility, you may enroll your Dependents within 30 days of the date you re-established your eligibility under the Plan. 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.

2. CONTINUATION OF COVERAGE RULES

Effective February 1, 2011, the following changes to continuation of coverage under the Plan will be made.

A. Elimination of Direct Self-Pay/Incorporation of Benefit into COBRA Continuous Coverage Under the Plan

The "Direct Self-Pay" option has been eliminated from the Plan as a stand-alone option for continuation coverage. Instead, the Trustees have incorporated this benefit into the changes made to your COBRA rights, which will allow you to maintain continuous coverage by making direct payments to the Plan through COBRA (see Section B, below).

B. Maximum COBRA Period for Loss of Coverage Due to Termination or Reduction in Hours

The prior COBRA period ended after a maximum of 18 months of continuation coverage. The Plan was amended to allow a maximum of 24 months of combined self-pay and temporary disability coverage without counting the first 6 months of disability coverage towards the 18-month COBRA period.

C. COBRA Maximum Payments

COBRA payments have been changed such that they cannot exceed **the lesser of** (1) the applicable premium and administrative charges, plus 2% or (2) the hourly employer Plan contribution rate multiplied by the number of hours required for one month of Plan coverage. If COBRA coverage goes beyond 18 months because of total disability, payment must **equal** the applicable premium and administrative charges, plus 50%.

D. Special Apprentice Rule for COBRA Coverage

Due to the incorporation of the Direct Pay benefit into COBRA, the Special Apprentice Rule is now part of the COBRA coverage.

E. COBRA Period Counted For Retiree Coverage Eligibility

Previously, any period during which your coverage under the Plan is extended pursuant to COBRA is not counted toward eligible periods required for you to obtain Retiree coverage. The Plan was changed to count all coverage extended pursuant to COBRA toward eligible periods required for you to obtain Retiree coverage.

F. HMOs To Contact Regarding Extension of COBRA

You should contact **Kaiser or Blue Shield HMO** for information regarding California's requirement that HMOs offer to continue benefits for certain individuals beyond the federal COBRA period in certain circumstances.

3. LONG TERM DISABILITY BENEFIT REQUIREMENTS

A. Deadline for Notice and Filing To the Plan

Effective October 1, 2010, to be eligible for Disability Benefits, you must notify the Plan Office and provide written proof of your disability no later than the later of: (1) 90 days after the end of the Waiting period or (2) **90 days after** the date your hour bank reserve account is exhausted.

B. Requirements To Qualify for Limited Benefits

Effective for October 2009 hours (December 2009 coverage), if you qualify for Limited Disability Benefits under the Plan, you will receive a maximum of one month of benefits for every month in which at least 120 hours of Employer contributions were made on your behalf during the 36 months immediately before your disability.. If you are working a 28-hour workweek, you will receive a maximum of one month of benefits for each month in which at least 112 hours of Employer contributions were made on your behalf.

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This Notice shall serve as a Summary of Material Modifications to your Plan and should be kept with your current Summary Plan Description for future reference.