SAN DIEGO ELECTRICAL HEALTH & WELFARE TRUST

Summary Plan Description
for covered active/retired participants
and their eligible dependents

Effective January 1, 2012

January 2012

TO: ALL PARTICIPANTS OF SAN DIEGO ELECTRICAL HEALTH AND WELFARE TRUST

We are pleased to provide you with this Revised Summary Plan Description outlining all coverages, Rules and Regulations, Plan provisions and relevant information pertaining to this Trust as of January 1, 2012. **It is important that you familiarize yourself with the contents of this booklet** as there are decisions that must be made which will result in very substantial savings to **both** you and the Trust. There is an extensive set of questions and answers at the end of the booklet that should help with your better understanding of the Plan and how to best utilize your coverages.

It is our intent to provide you, and your Covered Dependents, with the most comprehensive coverage affordable to the Trust. In recognizing that the cost(s) of medical, dental and vision services continue to escalate we continue to offer various options (i.e., PPO, HMO and supplemental life insurance) which are intended to permit you to select the most appropriate benefit package for yourself and/or your family, while also incorporating as many cost containment measures as possible.

This is why your fully understanding how the decisions you make may adversely affect you and the Trust financially becomes so very important. Every time an available discount is ignored, or a determination as to the most cost effective plan of treatment is not sought in advance, the costs to the Trust go up and may eventually result in the need to increase the number of hours required to maintain coverage each month, the cost per hour for Direct Payments, and/or the amount and application of deductibles or the percentage of co-insurance, etc.

We are proud of the fact that this Trust provides such excellent overall benefits and are always looking at ways to not only improve benefits, but to minimize the potential out-of-pocket costs to our participants. This can only be accomplished with the cooperation of all participants by complying with the requirements of the Plan and utilizing (whenever possible) the designated Providers offering discount arrangements.

One exciting new feature to the Plan are two programs focused on affording participants with the ability to independently verify medical diagnoses or treatment plans as well as making available information on recognized Centers of Excellence to consider when significant in an effort to achieve optimal medical outcomes. These programs have been implemented to assist participants in achieving optimal medical outcomes by being treated for correct diagnoses pursuant to the most appropriate plans of treatment and, for the most significant medical treatments, at highly renown facilities expected to deliver the highest quality of services.

We again urge you to familiarize yourself with the contents of this booklet, especially the information on the inside cover and on your identification card. Should you have any questions please make use of the quality staff in the Trust Office and secure your answers **before** a claim may be denied or an opportunity to derive the savings available to you and the Trust is lost.

A TELEPHONE CALL OR A VISIT TO A WEBSITE CAN SAVE YOU AND THE PLAN MONEY!!!

Very truly yours,

Board of Trustees
San Diego Electrical Health & Welfare Trust

Summary Plan Description
Table of Contents

PART ONE. . . . 1
Plan A. . . . 1
Trust Medical PPO Benefits. . . . 1
Eligible Expenses. . . . 5
Accident Expense Benefit. . . . 8
Physical Examination Benefits. . . . 8
Pregnancy Expense Benefits. . . . 9
Well Child Care Expense Benefits. . . . 9
Exceptions and Limitations. . . . 10
Kaiser Schedule of Benefits (HMO). . . . 14
Dental Benefits. . . . 15
Vision Benefits. . . . 18
Member's Assistance Program. . . . 20
MHN. . . . 20
Mental Health & Chemical Dependency Treatment. . . . 21
Home Health Care. . . . 21
Hospice Care. . . . 22
Life Insurance Benefits. . . . 23
Supplemental Life Insurance Benefits. . . . 23
Accidental Death and Dismemberment Benefit. . . . 24
Plan A Eligibility. . . . 25
Eligibility for Bargaining Employees 25
Continued Eligibility. . . . 25
Initial Eligibility. . . . 26
Termination. . . . 27
Re-qualification. . . . 27
Reserve Account. . . . 27
Direct Payments. . . . 28
Disability Credits. . . . 29
Armed Forces. . . . 30
Annual Enrollment. . . . 30
IBEW Reciprocal Program. . . . 30
Eligibility for Non-Bargaining Employees 31
Contributions. . . . 31
Eligibility. . . . 31
Reserve Account. . . . 32
Termination. . . . 32
Rules for Continuation Coverage Following Termination under COBRA for Plan A. . . . 32
Coverage after Termination from Trust Medical Plan. . . . 36
Plan A Service Providers. . . . 36
Preferred Provider Organizations (PPO). . . . 36
Hospital Pre-admission and Admission Review. . . . 37
Case Management. . . . 37
Pacific Foundation for Medical Care. . . . 37
Independent Medical Reviews. . . . 37
CVS/Caremark. . . . 37
Alere Disease Management. . . . 38
Best Doctors 38
Satori World Medical Centers of Excellence 38
Plan B. . . . 39
Schedules of Benefits for Plan B Kaiser (HMO). . . . 39
Eligibility Rules. . . . 40
Continued Eligibility. . . . 40
Initial Eligibility. . . . 41

Termination. . . . 41
Requalification. . . . 41
Reserve Account. . . . 42
Direct Payments. . . . 42
Disability Credits. . . . 42
Armed Forces. . . . 43
Continuation of Coverage Following Termination 44
Plan C. . . . 44
Schedules of Benefits. . . . 44
Non-medicare. . . . 44
Medicare. . . . 45
Rules of Eligibility. . . . 46
Premiums. . . . 47
Voluntary Retirees' Dental Benefits. . . . 49
HMO (Only in California) . . . 49
PPO (Nationwide) . . . 49

PART TWO. . . . 50
Definitions. . . . 50
General Provisions. . . . 55
Claim Procedures. . . . 55
Coordination of Benefits. . . . 56
Right of Recovery. . . . 59
Third Party Claims. . . . 60

PART THREE. . . . 62
Statement of Employee Rights under ERISA. . . . 62
COBRA. . . . 63
Qualified Medical Child Support Order. . . . 65
Family and Medical Leave Act. . . . 66
Military Service. . . . 66
The Newborns' and Mothers' Health and Protection Act. . . . 67
Women's Health & Cancer Rights Act. . . . 67
The Mental Health Parity Act. . . . 68
The Health Insurance Portability and Accountability Act (HIPAA). . . . 69
Other Important Information. . . . 72
How to File a Medical Claim. . . . 74
Claims Appeals Rules. . . . 75
Internal Review Process. . . . 76
External Review Process . . . 80

PART FOUR. . . . 83
Questions and Answers. . . . 83

IMPORTANT NOTICE

No benefits or coverage under the Plan shall be considered to be vested or guaranteed to any person. Only those persons who qualify for and/or are eligible to receive or utilize benefits under the Plan at a particular point in time shall be entitled to same. While it is the intent of the Board of Trustees to operate this Plan indefinitely, the Board reserves the right to amend, modify or terminate the Plan or any benefits thereunder, including Retiree benefits, if and when deemed necessary.

PART ONE

PLAN A

Note: Any term listed throughout this booklet that appears in **bold** type may be found in the Definition section and shall always be interpreted in accordance with their definition unless otherwise specified.

SCHEDULE OF BENEFITS FOR PLAN A

EMPLOYEE ONLY (EXCLUDING RETIREES):

Life Insurance (basic)	$10,000
Accidental Death and Dismemberment (Principal Sum)	$10,000
Supplemental Life Insurance	Optional

EMPLOYEE AND DEPENDENTS (INCLUDING RETIREES NOT COVERED UNDER PLAN C):

TRUST MEDICAL PPO BENEFITS

For Services Obtained from PPO and Non-PPO Providers

Annual Maximum	$2,000,000
Calendar Year Deductible	(The Deductible must be satisfied prior to any benefits being paid unless otherwise specified in the **Plan**)
• Per Person	$250
• Per Family	either two (2) full individual deductibles or up to a total of $750.

	Services Obtained From PPO Providers	**Services Obtained From Non-PPO Providers****
Co-Insurance Percentage	Covered at 80% of the first $7,500 of **Eligible Expense** incurred each calendar year with 100%* of the balance of such **Eligible Expense** up to the Annual Maximum.	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
HOSPITAL SERVICES		
• **In-patient** Services	Covered at 80% of the **Hospital**'s per diem rate or discounted **Allowable Charges**.	Covered at 60%.
• Deductible Per Admission (in addition to the Calendar Year Deductible)	None	$250.
• Room & Board	Covered at 80% of discounted **Allowable Charges**.	Covered at 60%.
• ICU/CCU	Covered at 80% of discounted **Allowable Charges**.	Covered at 60%.

	Services Obtained From PPO Providers	**Services Obtained From Non-PPO Providers****
• Out-patient **Hospital** Services	Covered at 80% of discounted **Allowable Charges**.	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
Deductible	$50.00 per occurrence unless admitted to the hospital.	$50.00 per occurrence unless admitted to the hospital.
Emergency Room (ER)		
• Due to **Emergency/urgent care** for accident or illness	Covered at 80% of discounted **Allowable Charges**.	Covered at 80% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
• Due to illness (for other than **Emergency /Urgent care**, including all **Physician** and/or related services)	Covered at 80% of discounted **Allowable Charges** only if admitted directly from ER. Otherwise, payable at 50% of discounted **Allowable Charges**.	Not Covered unless admitted directly from ER. If the **Hospital** is located outside of any area serviced by Blue Cross of California, coverage will be at 50%.
• Due to Accident (for other than **Emergency /Urgent care**, including all **Physician** and/or related services)	Covered at 80% of discounted **Allowable Charges** after exhaustion of Accident Benefits.	Covered at 80% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
Out-Patient Surgi-Center	Covered at 80% of discounted **Allowable Charges**.	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider up to a maximum of $350.
Skilled Nursing Facility	Covered at 80% of discounted **Allowable Charges**.	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
• maximum number of days per Calendar Year	90	90
• Ancillary Services	Covered at 80% of discounted **Allowable Charges**.	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
PHYSICIAN AND SURGEON SERVICES (in-patient or out-patient, other than emergency room **Physicians**)	Covered at 80% of discounted **Allowable Charges**.	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
• Emergency Room Physicians (for **emergency/urgent care** services for an accident or illness in a **Hospital**)	Covered at 80% of discounted **Allowable Charges**, if applicable. Otherwise, 80% of total charges.	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.

	Services Obtained From PPO Providers	**Services Obtained From Non-PPO Providers****
OUT-PATIENT MEDICAL SERVICES (In **Physician**'s office) • office visits	Covered at 100% of discounted **Allowable Charges** without application of a deductible, after payment of an office visit co-pay as follows: For all Sharp Health System **Physicians** -$10 For all other **PPO Physicians** in San Diego County-$30 For **all PPO Physicians** outside San Diego County-$15	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
• diagnostic laboratory and • x-ray • surgery • radiology • pathology • physical therapy (Subject to pre-approval by PFMC)	Covered at 80% of discounted **Allowable Charges**.	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
PREGNANCY BENEFITS (**Physician** services only)	Covered at 80% of discounted **Allowable Charges**.	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
• Well baby/child care (**in-patient** or **out-patient** up through age 19)	Covered at 80% of discounted **Allowable Charges**	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
HOME HEALTH CARE	Covered at 80% of discounted **Allowable Charges**.	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
HOSPICE CARE	Covered at 80% of discounted **Allowable Charges**.	Covered at 60% of the maximum **Allowable Charge** as if the service(s) had been rendered by a PPO Provider.
PHYSICAL EXAMINATION PROGRAM • **Employee** and **Spouse** Only (See page 8)	Covered at 100% without application of a deductible. Services must be rendered at a Sharp Rees-Stealy Occupational Medicine Facility.	Not covered
	OR	
Employee and **Spouse** Physician's Examination (See page 8)	Covered at 100%* of discounted **Allowable Charges,** including a maximum office visit charge of up to $80.	Not Covered

Services Obtained From PPO and NON-PPO Providers

ACCIDENT BENEFITS	Covered at 100%* of **Allowable Charges** up to $300., with the balance of **Eligible Expenses** payable in accordance with the Schedule of Benefits.
MANIPULATIVE SERVICES	Covered at 80% of **Allowable Charges** up to $575.00 per calendar year, including services such as chiropractic, acupuncture and other manipulative services/modalities subject to a daily limit as provided in item 21 under "Eligible Expenses" on page 7.
MENTAL HEALTH/ SUBSTANCE ABUSE BENEFITS	
• **Out-Patient**	As part of the Members' Assistance Program (through Horizon EAP, formerly Integrated Insights) up to a maximum of eight (8) sessions in any twelve (12) month period by a professional counselor of Horizon EAP Any additional **out-patient** treatment must be referred to MHN by Horizon EAP.
• **In-Patient** (including treatment for alcohol and substance abuse)	For other than an emergency only upon referral to MHN by Horizon EAP
PRESCRIPTION DRUGS	For qualified new and refill prescriptions filled at a CVS/Caremark pharmacy the **Plan** will pay as **Eligible Expense**, without application of a deductible, up to a maximum of a 30-day supply. However, an 84-90 day supply will be permitted for any prescription designated by CVS/Caremark to be a maintenance drug. All maintenance drugs must be purchased through a Caremark Mail Pharmacy or at a CVS Pharmacy pursuant to the Maintenance Choice Program in order to be covered by the **Plan** with the exception of any 84-90 day supply refill purchased at local pharmacies designated by CVS/Caremark as participating in its "Maintenance Choice" Program. The **Plan** will pay 80% for generic drugs, which shall be required for all prescriptions unless there is no generic substitution for a brand name, or for the most cost effective preferred brand name within a comparable class of drugs as determined by CVS/Caremark. However, if a generic alternative or a more cost effective preferred brand name drug is available, but a non-preferred brand name drug is purchased instead, the **Plan** will pay 40% of the cost. The actual amount to be paid by the Plan will be determined at the time of purchase in accordance with the negotiated discount through Caremark. The **Plan** also requires that refills of all maintenance medications, as determined by CVS/Caremark, must be purchased via mail order directly from Caremark Mail Pharmacy pursuant to the above mandatory generic/preferred brand name requirement and co-payment criteria. Further, all injectable medications must be purchased directly through the SpecialtyRx program of CVS/Caremark in order for the cost of the medication to be covered by the **Plan**. In the event a **Covered Person** does not utilize a CVS/Caremark pharmacy or SpecialtyRX to fill a prescription, pursuant to the mandatory generic/preferred brand requirement, the above pricing criteria will be applied to the extent the **Plan** will not pay more than it would have if the prescription(s) had been properly filled at the CVS/Caremark pharmacy or SpecialtyRx, with the actual cost for pricing purposes to be determined in accordance with the negotiated discount through Caremark.

* Where other group insurance exists, the **Plan**, if primary payor, will pay all **Eligible Expenses** exceeding the deductible at 60%, unless the secondary payor is an HMO/ Managed Care Program for which there would be no benefits payable for the services rendered. If the plan or policy of a secondary payor provides coverage for medical expense benefits that does

not make payment for the balance of **Eligible Expense** the **Plan** will make additional payment to cover up to the balance of **Eligible Expenses** due. However, **except for services rendered through an HMO/Managed Care Program for which there would be no be** benefits payable for services rendered **,** the **Plan** ,as primary payor, will not make total payments in excess of 80% of **Eligible Expense.** Further, if this **Plan** is in a secondary position, and the provisions of the primary plan would require payment by this **Plan** of greater than 20% of **Eligible Expense** to result in 100% of **Eligible Expense** being paid on behalf of the **Covered Person**, then payment under this **Plan** shall be limited to no more than 20% of said **Eligible Expense**.

** Where the services of a Non-PPO **Provider** are related to **emergency care** or are rendered outside the geographic areas serviced by Blue Cross, benefits will be paid in accordance with the Schedule of Benefits for PPO **Providers**, subject to any exclusions and/or limitations in the **Plan**. However, the total of **Eligible Expenses** to be payable relative to an admission into a non-PPO **Hospital** for other than **emergency or urgent care** shall be reduced by 25% prior to determining the amount payable by the **Plan** in accordance with the Schedule of Benefits. In an instance where a non-PPO provider has agreed in writing to accept the PPO maximum allowance as payment in full on behalf of the **Plan** and the participant, the **Plan** will make payment in accordance with the Schedule of Benefits for PPO Providers, subject to any exclusions and/or limitations in the **Plan**.

DESCRIPTION OF BENEFITS

TRUST MEDICAL BENEFITS

When **Bodily Injury** or illness causes a **Covered Person** to incur medical expense, the **Plan** will pay the applicable percentage of the **Eligible Expenses** actually incurred as a result of said injury or illness. Said benefits will be payable only after application of the applicable deductible and up to the Maximum Amount payable, as stated in the Schedule of Benefits.

The deductible shall be the total of the cash amount specified in the Schedule of Benefits. Such deductible must first be satisfied each calendar year by the application of expenses incurred as listed below before any such expenses incurred will be payable as benefits under the **Plan**.

Eligible Expenses incurred during the last quarter of the immediately preceding calendar year which were applied to the deductible for the preceding calendar year will also be included as expenses incurred for the current calendar year, and applied to the deductible for the current calendar year, provided the entire for the preceding calendar year was satisfied by application of such expenses.

In the event more than one **Covered Person** in the same family is injured by reason of any one accident only one deductible will be applied to all such **Covered Persons** as the result of such accident.

"MAXIMUM AMOUNT PAYABLE" means the amount stated in the Schedule of Benefits for all **Eligible Expenses** incurred for all accidents and illnesses combined. All coverage under the **Plan** will terminate as to a **Covered Person** on the date the Lifetime Maximum Amount is paid or becomes payable.

Whenever benefits become payable on behalf of a **Covered Person** under the **Plan** an automatic restoration of a portion of benefits shall be applicable. This automatic restoration shall be equal to the lesser of $5,000 or the entire portion of the Lifetime Maximum Amount Payable which has not previously been reinstated, and shall become effective as to the **Covered Person** on the first day of each succeeding calendar year. However, in the event the **Covered Person's** coverage is terminated for any reason, restoration of part or all of the Lifetime Maximum shall be deferred until eligibility is re-established.

ELIGIBLE EXPENSES

"**Eligible Expense(s)**" means the following charges, not in excess of the **Allowable Charges** made by the person, group or other entity for the services rendered or the supplies furnished when actually made to or on account of a **Covered Person** for services or supplies which are necessary to the care and treatment of **Bodily Injury** or illness and are ordered by doctor or a **Physician**:

A. **Hospital** Expenses for room and board and the following miscellaneous **Hospital** expenses: Operating room, medicines, drugs, unreplaced blood and blood plasma (including administration thereof), anesthetic (including administration thereof in a **Hospital** by a **Physician**), X-ray examinations, radiation treatments, physiotherapy, laboratory tests, surgical dressings and medical supplies, and **Hospital** ambulance service;

B. Surgical Expenses for procedures performed in or out of a **Hospital** for necessary surgical procedures (including necessary related post-operative care) by **Physicians** to include charges for the sterilization of a male or female **Covered Employee** or **Covered Spouse**. Charges for the services of an assistant surgeon up to 20% of the **Allowable Charge** for the surgical procedure;

C. Additional Expenses, if not included under Subsection A. and B. above for:

(1) Treatment by a legally qualified **Physician** excluding expenses which are related to surgical procedures; however, **Eligible Expenses** of a licensed mental health professional, who is referred by a **Physician**, for **out-patient** treatment of **Psychiatric Conditions** for **Covered Persons** residing outside of the geographic area serviced by Horizon EAP (formerly Integrated Insights) and/or MHN shall be payable at 50% of such **Eligible Expenses** up to a maximum of 15 visits per Calendar Year;

(2) Services of a licensed registered graduate nurse or of a licensed practical nurse rendered in or out of a **Hospital** and also the services of a licensed undergraduate nurse provided such service is rendered in a **Hospital**, other than by a person who ordinarily resides in the **Covered Person's** home or who is a member of the **Covered Person's** immediate family (consisting of the **Covered Person's Spouse**, children, brothers, sisters and parents), as prescribed by a **Physician**, not to exceed $1,000 in **Eligible Expenses** during any Calendar Year. However, additional nursing services shall be considered as **Eligible Expense** if approved by Blue Cross as part of its Case Management services;

(3) Anesthesia and its administration, whether performed in or out of a **Hospital**;

(4) Treatment for physical, speech, vision and **occupational** therapy or learning and developmental disabilities, if deemed to be the result of a medical condition covered by this **Plan** and prescribed by a **Physician** whose plan of treatment must be pre-approved by the Pacific Foundation for Medical Care, or for correction of congenital or developmental abnormalities as provided by a licensed therapist (other than a member of the **Covered Person's** immediate family defined above) for rehabilitation of an injury or illness. However, all such therapy is limited to 6 visits per disability unless additional visits are approved by the Pacific Foundation for Medical Care;

(5) Dental treatment by a **Physician**, Dentist or dental surgeon for a fractured jaw or for injury to sound natural teeth, including replacement of such teeth within 12 months after the date of the accident and while the **Covered Person** has been continuously covered by the **Plan**;

(6) X-ray or radium treatment;

(7) Radiology, pathology or x-ray and laboratory examinations, excluding dental x-rays unless rendered for dental treatment of a fractured jaw or of injury to sound natural teeth within 12 months after the date of the accident and while the **Covered Person** has been continuously covered by the **Plan**;

(8) Ambulance charges for necessary local transportation of a **Covered Person** by professional ambulance service from the place of injury or onset of illness to the nearest **Hospital** for in-patient care, or to the nearest **Hospital** for emergency accident care where the necessary treatment is available. In cases of life threatening illness or injury air ambulance services for the patient(s) will be permitted only to the nearest **Hospital** providing the necessary facilities;

(9) Medical Supplies shall include drugs and medicines obtainable only pursuant to a prescription from a **Physician** and dispensed by a licensed pharmacist; blood and blood plasma (when not replaced); artificial limbs and eyes; surgical dressings; casts; splints; trusses; braces; crutches; rental of wheel chairs; hospital bed; iron lung; or other durable therapeutic devices including oxygen and the rental of equipment for its administration, to the extent such total rental costs do not exceed a reasonable purchase price, as determined by the **Plan**;

(10) The daily service expense of a **Skilled Nursing Facility** immediately following **in-patient Hospital** care in accordance with the Schedule of Benefits for each day of confinement as a registered **in-patient**, but only upon referral by a **Physician** for convalescence from an illness which commenced, or an injury which occurred, while being a **Covered Person** and as approved by Case Management;

(11) For each female **Covered Employee, Spouse or Dependent** one routine Papanicolaou (PAP) type cytologic smear and/or for women age 30 and older one Human Papilloma Virus (HPV) test (limited to the **Allowable Charge** for the laboratory and related intermediate **Physician's** office visit) and one mammography examination separated by at least 12 months. Charges for a routine Pap smear will be payable at 100%* (see * in Schedule of Benefits on page 9) of the **Allowable Charge.** Charges for a routine Human Papilloma Virus (HPV) test to be payable at 100% * of the **Allowable Charge** up to a maximum of $100;

(12) For each female **Covered Employee** or **Spouse** one mammography examination separated by at least 12 months;

(13) For each female **Covered Employee, Spouse** or **Dependent** no more than one implantation of an FDA approved birth control device within a three to five-year period (depending on the normal longevity of the device), as well as no more than one removal within the same period of time;

(14) The initial corneal lens following cataract surgery performed while covered under the **Plan**, but only for the eye on which surgery was performed;

(15) For any **Covered Person** undergoing chemotherapy or radiation therapy, no more than one prosthetic hair replacement device within a five-year period, subject to a maximum of $300;

(16) Charges for any **Covered Person** relating to prescribing, fitting, the cost of manufacturing and/or any related therapy for orthotics billed or dispensed by a **Physician**, limited to one pair per calendar year;

(17) The **Usual, Customary and Reasonable** charges for any **Medically Necessary** services and supplies recommended by Case Management, and approved by the **Covered Person's** attending **Physician**, which are in lieu of **Eligible Expenses** not otherwise recognized as **Eligible Expenses** in this **Plan** but are reasonably expected to result in reduced aggregate benefit payments by the **Plan** in contrast to the **Covered Person** receiving only **Medically Necessary** services and supplies recognized as **Eligible Expense** in this **Plan**;

(18) Charges for any **Covered Employee** receiving a series of three hepatitis "B" vaccinations, as well as re-vaccination (booster doses) administered at least 5 years following the last dose from the previous series;

(19) Charges for all preventative vaccinations, all updated recommended vaccinations, including Hepatitis "B" and those recommended for international travel, to be payable at 100% of the maximum allowable charge without application of a deductible.

Charges for all "Preventive Health Services" in accordance with the provisions of the Interim Final Regulations under the Patient Protection and Affordable Care Act ("PPACA), or as may be subsequently amended, will be provided at no out of pocket cost to the **Covered Person**. However, where the then current list of services to be recognized under PPACA does not specify the frequency, method, treatment, or setting for the provision of a particular service the **Plan** shall determine any applicable coverage limitation or exclusion of that service based on medical necessity or medical appropriateness using prior authorization requirements, concurrent review, or other industry recognized practices;

(20) Charges for any **Covered Person** relating to prescribing, fitting and/or the actual cost of a hearing aid for either ear dispensed by a **Physician** no more frequently than every three (3) years, subject to a maximum **Allowable Charge** of $1,000 per hearing aid;

(21) Charges for all chiropractic, acupuncture, manipulative services and/or related modalities, excluding laboratory and x-ray, up to $102.06 for the initial visit and $41.84 for each subsequent visit up to a maximum of $575 in benefits payable in a Calendar Year and subject to a limitation of one visit per day;

(22) Charges for Viagra, pursuant to a valid prescription for the **Covered Person**, subject to a maximum dosage of 8 pills per calendar month;

(23) Charges for flu shots and other immunizations which are deemed by a **Physician** to be medically necessary or for preventative purposes; ~~and~~

(24) Upon submission of a receipt of payment and a certificate of completion from a recognized smoking cessation program the **Covered Person** will be reimbursed 50% of the cost of such a program, up to a maximum of $100; and

(25) For all covered services and supplies in connection with out-patient surgery performed at an ambulatory surgical center (for other than **emergency or urgent care**) that is not a PPO provider as of the date of service, the maximum benefit payable by the **Plan** in accordance with the Schedule of Benefits will be $350.

Provided, however, that no expense incurred shall be payable or included in any computation of payment under more than one of the above categories.

ACCIDENT EXPENSE BENEFIT

These benefits are payable if a **Covered Person** sustains **Bodily Injury** and incurs expenses within 90 days after the accident for charges made for **Hospital,** medical or surgical services, or services of a licensed nurse or therapist (an R.N. or L.P.N. not related to or living with the **Covered Person**) that are necessary for the diagnosis and treatment of such injury and are recommended or approved by a **Physician**.

Benefits Payable. Benefits are payable, without application of a deductible, for such expenses not reimbursable under other provisions of the **Plan**; however, the total amount payable under this provision for all expenses incurred as a result of injuries sustained in any one accident will not exceed the maximum benefit stated in the Schedule of Benefits.

Additional Exclusions. No Benefits are payable under this provision of the **Plan** for Dental services of any kind, except for the injury to sound natural teeth in which case the **Covered Person's** dental carrier, if applicable, would be primary and benefits will only be payable by the **Plan** to the extent the maximum benefit has not been exhausted.

ROUTINE PHYSICAL EXAMINATION BENEFIT

Each **Covered Employee** and **Covered Spouse** will be entitled to a confidential health risk appraisal/physical examination (not due to **Bodily Injury** or illness) performed either through the pre-arranged program with Sharp Rees-Stealy or by any other PPO **Physician**. The Plan will not cover any charges relative to a routine physical exam performed by a non-PPO **Physician**. Charges for the following schedule, listing both eligible services and frequency of subsequent examinations, will be payable at 100% of the maximum allowable charges, without application of a deductible, for services rendered through the Sharp Rees-Stealy program. A routine physical examination by any other PPO **Physician** will be payable at 100%, up to $80, for an office visit, without application of a deductible, and at 80% of the maximum allowable charges with application of a deductible, if necessary, for all other scheduled services.

ROUTINE HEALTH APPRAISALS FOR EMPLOYEES & SPOUSES

Choice of Providers:

Sharp Rees-Stealy Occupational Medicine:	Covered at 100%
PPO Member Physicians:	
• Annual Pap Tests	Covered at 100%
• Office Visit	Covered at 100% up to $80 (no deductible)
• All Other Scheduled Services	Payable at 80% of maximum allowable charges, subject to deductible.

BENEFITS

(1) BASIC APPRAISAL

A. Covered Services

(1) Health Risk Questionnaire and Evaluation
(2) Complete History and Physical by a Physician
(3) Complete Blood Count and Cholesterol Test
(4) Urinalysis
(5) Update recommended preventative vaccinations

B. Frequency of Covered Health Appraisals

(1)	Under age 30:	Every 5 years
(2)	Ages 30 to 39:	Every 4 years
(3)	Ages 40 to 49:	Every 3 years
(4)	Ages 50 to 59:	Every 2 years
(5)	Ages 60 or older:	Annually

(2) SPECIFIC ADDITIONAL TESTS

The Plan will also cover the following specific tests provided at the time of the health appraisal:

Test	Frequency
Pap Smear/HPV Test* * Age 30 and over	Annually
Mammogram	Annually
PSA Test	Each Appraisal over age 50 or at Physician direction, if medically indicated
Colon Cancer Screening - Either: A. Sigmoidoscopy (and annual Occult Blood Test) **or** B. Colonoscopy	Every 3-5 years at physician's discretion Every 10 years over age 50
EKG	At physician discretion based on age and risk factors/history

PREGNANCY

If a **Covered Employee** or the **Covered Spouse** or **Dependent** of a **Covered Employee** incurs medical expenses on account of **pregnancy**, the **Plan** shall pay the benefits on the same basis as any other illness subject to the Schedule of Benefits. **Pregnancy** shall be deemed to have commenced nine months prior to the actual delivery of the newborn child(ren), unless a different commencement date is established by a **Physician's** written statement or documentation from recognized testing for such purposes.

It shall be recognized that services rendered to the mother or child during **pregnancy** and/or for the delivery of a newborn child shall be considered as treatment to the mother and not the unborn child. It is further recognized that services rendered by a licensed midwife and certified nurse midwife will be considered as **Eligible Expense** provided the service **Provider** is practicing within the scope of their license and in accordance with laws of the State where such service(s) are rendered.

WELL CHILD CARE

If a **Covered Dependent Child** under age 19 incurs medical expense for routine medical examinations and/or immunizations in accordance with the following schedule, the **Plan** shall pay benefits on the same basis as any other illness subject to the Schedule of Benefits. The following schedule of examinations and immunizations is in accordance with the recommendations of the American Academy of Pediatrics:

Age for Exam	Extent of Exam: Routine Exam Plus
Birth to 4 Days	Metabolic screening, Hepatitis B shot
1 Month	Metabolic screening

Age for Exam	Extent of Exam: Routine Exam Plus
2 Months	Diphtheria, Pertussis and Tetanus (DPT) - Haemophilus Influenza (HIB) and Polio immunizations
4 Months	DPT-HIB, Polio and Hepatitis B immunizations
6 Months	DPT-HIB immunization
9 Months	Hepatitis B immunization, Lead testing and Hemoglobin test
12 Months	Chicken Pox and Measles, Mumps & Rubella (MMR) immunizations
15 Months	Polio, DPT-HIB immunizations
18 Months	no additional services
24 Months	Lead testing
3 Years	Blood pressure, vision and hearing tests
4 Years	Vision and hearing tests
5 Years	DPT and Polio immunizations, Urinalysis
6-10 Years (every other year)	Measles, Mumps & Rubella (MMR) at age 6
11-18 Years (annually)	Tetanus shot once between ages 11-16; Hepatitis B: 3 doses between ages 11-12 if not previously vaccinated. Chicken Pox: once between ages 11-12; if deficient. Blood pressure - annually. Urinalysis and Hemoglobin tests at age 15.

However, other routine medical examinations or immunizations required for school, athletics are not covered under the Well Child Care benefit unless otherwise specified in the Plan.

EXCEPTIONS AND LIMITATIONS

This **Plan** does not cover any of the following services, supplies and expenses and the fact that a service or supply is **Medically Necessary** or that a **Physician** may prescribe, recommend or approve a service or supply does not make the expense for that service or supply an **Eligible Expense** unless expressly provided for in this Plan Document:

(1) Any services or supplies furnished or provided under any governmental plan, including, but not limited to, CHAMPUS, CHAMP V.A., and Parts A and B of Medicare, except as required under the Tax Equity and Fiscal Responsibility Act of 1982; or

(2) Any **Bodily Injury** or illness for which the person on whom claim is presented has or had a right to compensation under any Worker's Compensation or Occupational Disease law or which arises from or is sustained in the course of any occupation or employment for compensation, profit, or gain; or

(3) Any expenses for services or supplies, the expenses of which would be payable by any other employer sponsored plans, or other employee benefit or union sponsored plans, under the Coordination of Benefits provision of this **Plan**; or,

(4) Any supplies or services (a) for which no charge is made, or (b) for which the individual is not required to pay, or furnished by or payable under any plan or law of any Federal or State, Dominion or Provincial Government, or (d) furnished by a County, Parish, or Municipal **Hospital** when there is no legal requirement to pay for such supplies or services; or

(5) Any **Bodily Injury** or illness caused by war or any act of war (declared or undeclared) or nuclear energy (except when being used for medical treatment of an illness or **Bodily Injury**) or military service of any Country; or

(6) Any **Bodily Injury** or illness for which the person for whom claim is presented is not under the regular care of a **Physician**; or

(7) Any **Bodily Injury** or illness which arises from the person being charged with a felony or attempted felony or participating in a riot, insurrection or civil commotion; or

(8) Any charges for eye refractions, the fitting or cost of eye-glasses or hearing aids, contact lenses (except as provided under **Eligible Expenses**), corrective shoes or other corrective devices or appliances, (except as provided under **Eligible Expenses**); or

(9) Any charges for cosmetic surgery which term shall include, but is not limited to: (1) surgery to the upper and lower eyelid; (2) penile implant; (3) augmentation mammoplasty or reduction mammoplasty; (4) full or partial facial lift; (5) derma or chemo-abrasion; (6) scar revision; (7) otoplasty; (8) lift, stretch or reduction of abdomen, buttocks, thighs or upper arm; (9) silicone injections to any part of the body; and (10) rhinoplasty; unless such treatment or operations are for repair of disfigurement resulting from an **Accidental Injury**, provided such treatment commences within two years after such injury was sustained or unless such treatment or operation(s) is/are for correction of a congenital birth anomaly in a **Covered Child** or for reconstructive surgery or other related services incident to a mastectomy;

The term "other related services" means surgery and reconstruction of the other breast to provide a symetrical appearance and provision of prostheses and services in connection with other complications, including lymphademas.

(10) Any charges for routine physical examinations/health appraisals or tests for check-up purposes and which are not incident and necessary to the treatment of **Bodily Injury** or illness, except as provided for in the Schedule of Benefits; or

(11) Any nursing expense, except as provided under **Eligible Expenses**; or

(12) Any expenses that are made only because this **Plan** exists, or charges which the **Covered Person** is not legally obligated to pay; or

(13) Any charges with respect to the care or treatment of nervous or mental disorders, mental or emotional illness, disorder or disturbances, or other **Psychiatric Conditions**, except for such services rendered through the MHN, following referral by the Member Assistance Program or as provided by the Member Assistance Program; or

(14) Any Bodily Injury or illness caused by accident involving the operation of, or riding in or on, any motorized vehicle used for, or in, any form of organized racing and/or contest(s) of speed, endurance or agility; or

(15) Any **Bodily Injury** or illness resulting from the injured person being under the influence of any narcotic or barbiturate unless administered on the advice of a **Physician** and taken in accordance with the prescribed dosage, or for loss sustained or contracted in consequence of the ingestion or use of hallucinatory drugs; or

(16) Any charges incurred as a result of obesity including any surgery, revision or repair as a result thereof including expenses, service or treatment for any form of food supplement or augmentation (unless necessary to sustain life in a critically ill person); or for any exercise program; or for weight control or removal of weight or fat, whether for obesity or for any other diagnosis and whether by diet, injection of any fluid, or use of any medication or surgery of any kind, except when deemed **Medically Necessary**, after Peer Review and per Case Management, for the treatment of existing diseases which are clearly aggravated by obesity; or

(17) Any expense for services rendered by an assistant surgeon who is not a **Physician** unless their service is **Medically Necessary**; or

(18) Any charges for foot care solely for improvement of comfort or appearance (i.e. care for flat or pronated feet, subluxation, corn, bunions [except capsular and bone surgery], callouses, toenails, chronic foot strain, etc.); or

(19) Any charges incurred for vision, speech, physical or **occupational** therapy except as provided under **Eligible Expenses** or in the Schedule of Benefits; or

(20) Any expenses for experimental or investigative therapy including any type of therapy not determined to be **Medically Necessary** by the Pacific Foundation for Medical Care, in accordance with American Medical Association's Diagnostic and Therapeutic Technology Assessment program, the Food and Drug Administration of the U.S.; or

(21) Any treatment deemed not to be **Medically Necessary** in accordance with generally accepted medical standards or determined to be in connection with experimental/investigative treatment by the Pacific Foundation for Medical Care. In any instance the **Plan** reserves the right to utilize the American Medical Association's Diagnostic and Therapeutic Technology Assessment program and/or Drug Information Section and/or independent medical Consultant opinions; or

(22) Any charges incurred as a result of **Custodial Care**; or

(23) Any charges for services in connection with educational, learning or developmental disabilities, except as provided under **Eligible Expenses**; or

(24) Any expense for male or female reversal of sterilization, sex change or implantation with any sex organ or any expense for correction or to assist in correcting or testing for impotency, fertility or infertility (other than charges for the initial diagnosis of infertility or charges for Viagra as provided under **Eligible Expenses**), whether voluntary or otherwise, or any related hormone therapy; or charges for or in connection with preconception testing or genetic testing, by whatever name known, for the purpose of determining sterility, or lack thereof, as well as charges relating to artificial insemination or in-vitro fertilization procedures; or

(25) Any tooth extractions or other dental work or surgery that involves any tooth or tooth structure, alveolar process, abscess, periodontal disease or disease of the gingival tissue, except as provided under **Eligible Expenses**, as well as any care or treatment of the teeth or the fitting or wearing of dentures; or any care or treatment of teeth, gums, jaws, or jaw joints including, but not limited to, atrophy of the lower jaw, occlusion, maxillofacial surgery, craniofacial, skeletofacial or orthognathic surgery, temporomandibular joint dysfunction (TMJ) and retrognathia, prognathism, microgenia, apertognathia or other malformation, maldevelopment or malrelation of the jaws or their processes; however, this exclusion shall not apply to treatment of accidental injury to sound natural teeth (including their replacement) all treatment occurs within twelve months after the date of injury or the surgical repair of temporomandibular joint dysfunction (TMJ). However, this exclusion will not be applicable when a surgical procedure for the treatment of the jaws or jaw joints intended to improve a physical function impairment has been determined to be medically necessary by independent review; or

(26) Any charges for service or treatment due to altering the size or shape of the breast, male or female, except for reconstructive surgery due to mastectomy; or

(27) Any charges for the treatment of **Psychiatric Conditions**, including alcoholism, narcotism or substance abuse, through other than the MHN following referral by the Member Assistance Program; or

(28) Any charges for more than one routine ultra-sound examination per **pregnancy** or one amniocentesis test per **pregnancy**, if the latter is performed for medical purposes; or

(29) Any expenses relating to a **Hospital** admission, except where the admission is the result of an **urgent or emergency** admission, where the **Covered Person** or his **Physician** failed to notify Blue Cross or the then current PPO or alternate service provider retained to perform this and/or any related services in advance of the admission and is subsequently determined to have been **medically** un**necessary**; or

(30) Any charges for quantities of covered drugs, medicine and medical supplies as prescribed by a **Physician** which exceed the usual and customary quantity that would be used during a period, subject to a maximum of a 30-day supply unless otherwise specified in the **Plan**. However a 90-day supply will be permitted for any prescription designated by Caremark to be a maintenance drug; or

(31) Any charges for local ambulance service other than as provided under **Eligible Expenses**; or

(32) Any expenses for an organ transplant, except that this limitation shall not apply when the transplant is for a cornea, heart, lung, heart-lung, liver, pancreas, kidney, bone marrow (including autologous bone marrow transplants), or of tissue obtained from the body of the **Covered Person**. Expenses incurred by a live human organ donor who is covered by the **Plan** shall be considered as **Eligible Expenses** of the organ recipient. However, if the donor is without insurance coverage a maximum of $20,000. shall be considered as **Eligible Expenses** of the recipient. All expenses related to any other source of organ donation or procurement will be limited to a maximum of $20,000.; or

(33) Any expenses for abortions unless the life of the mother would be endangered if the fetus were carried to term or there is clinical evidence of fetal abnormality; however benefits will be provided for expenses incurred due to medical complications which may arise following an abortion; or

(34) Any charges related to a **pre-existing condition** except that the exclusion from coverage of any **Pre-existing Condition** will be removed, and **Eligible Expenses** for the treatment of such condition(s) will be payable subject to all other provisions of this **Plan**, after the **Covered Person** has been covered by this **Plan** for 12 consecutive months or to the extent by which the 12 consecutive month period is reduced or eliminated in accordance with the Health Insurance Portability Accountability Act of 1996 (HIPAA); or

(35) Any expenses for drugs and medicine for the purpose of contraception for a female **Covered Employee** or **Covered Spouse** in excess of a maximum benefit payable of up to $55 for a one month supply or in excess of $1,000 for the implantation of a birth control device within a three year to five yea period (depending on the normal longevity of the device), except that a drug or medicine which is prescribed by a **Physician** and which would otherwise be a covered item, shall not be excluded from coverage only because it may incidentally have a contraceptive effect; or

(36) Any charges for more than one routine Pap smear and/or mammography test for a female **Covered Employee** or **Covered Spouse** within any 12 consecutive month period; or

(37) Any expense for prosthetic devices, even if prescribed by a **Physician**, for the replacement of an existing prosthetic device unless the replacement is due to a necessary modification or modifications which cannot reasonably be made to the existing device; or

(38) Any charges in connection with cytotoxic testing; or

(39) Any charges in connection with chelation therapy, except charges for treatment of proven heavy metal poisoning;

(40) Any charges for the rental of **Durable Medical Equipment** which exceeds the purchase cost. With respect to **Durable Medical Equipment** charges for repair, maintenance, replacement due to wear and tear, loss, theft, breakage and/or personal desire are excluded. Also excluded are charges for commodes, treadmills, equipment for inversion therapy, weight training or exercise, as well as any modifications made to dwellings, property or automobiles such as ramps, elevators or stair lifts, swimming pools, spas, air conditioners/air filtering systems or car hand controls, etc., whether or not their installation is for purposes of providing therapy or easy access and whether or not the equipment is prescribed by a **Physician**. However, these exclusions do not apply if such equipment is approved by Case Management;

(41) Any pregnancy related expenses incurred by a **Covered Person** if there exists a surrogacy contract or agreement providing for the newborn child to become the dependent of other than the **Covered Employee** or their **Covered Spouse**;

(42) Any charges for more than one visit to a **Physician's** office or by that same **Physician** on the same day unless the **Covered Person** is confined as a registered bed patient in a hospital or extended care facility. "Multiple office visits" is hereby defined as more than one office visit being charged by the same **Physician** for the same date of service unless it can be substantiated that the **Covered Person** returned to the **Physician's** office for a subsequent visit. However, medically necessary service rendered in conjunction with an ineligible office visit charge pursuant to this provision may be covered provided it qualifies as **Eligible Expense** under the **Plan**; and

(43) Any charges by a hospital, surgi-center, healthcare facility or a physician related to and/or which constitute a "Never Event" or "Hospital Acquired Condition", as defined herein, or that may be directly or indirectly related to or the result of medical malpractice when identified by the **Plan** prior to receipt and processing of claims.

In the event a malpractice is discovered after related claims have been submitted and processed the **Plan** reserves its right to pursue recovery in accordance with its "Right of Recovery" provisions.

For the purpose of this provision the following definitions shall be applicable:

a. "Never Events" are events that are preventable, serious and unambiguously adverse to the patient that should not occur and constitute a Serious Reportable Event per the National Quality Forum; and

b. "Hospital Acquired Conditions" are conditions that were not present on admission and could have been reasonably prevented. Hospital Acquired Conditions will be determined in accordance with guidelines and indicators established by the Center for Medicare & Medicaid Services ("CMS") as to the reporting of same by hospitals, surgi-centers and healthcare facilities which require that all such "Preventable Adverse Events" be identified by the facility, reflected on their claim submission, that all related charges (including those that would not have existed but for the event) not be submitted for payment, and that no party be billed for same.

PLAN A KAISER SCHEDULE OF BENEFITS (HMO)

The basic premise of an HMO plan is that the **Covered Person** receives most services at no out-of-pocket expense so long as recognized **Hospitals** and **Providers** are utilized. However, in some instances there are co-payments required to be paid on a fee for service basis. The following is a brief description of the current Schedule of Benefits, while all pertinent information is contained in the brochure ***Your Health Plan Coverage*** published by Kaiser Permanente, available at the Trust Office.

EMPLOYEE AND DEPENDENTS - Kaiser **Plan A** (Including Retirees Not Covered Under Plan C)

Type of Service	**Co-Payment**
Hospital	
• All services including Physician visits	No Charge
Physician	
• Office Visits, physicals, vision and hearing exams, well child care, therapy(ies), prenatal visits & 1st postnatal visit	$15 per visit
• laboratory, x-ray, diagnostic tests, allergy injections, immunizations	No Charge
Ambulance - Within service area	$50 per trip
Home Health Care	No Charge
Hospice Care	No Charge
Skilled Nursing Care	
• Up to 100 days per calendar year	No Charge
Covered Prescriptions	
• Generic from plan pharmacies	$10.00 per prescription per 30-days or $30.00 for a 61-100 day supply)
Generic refills from mail order	$10.00 per prescription per 30 days or $20.00 for a 31-100-days supply
Brand drugs from plan pharmacies	$20.00 per prescription per 30-days or $60.00 for a 61-100 day supply)
Brand drug refills from mail order	$20.00 per prescription per 30-days or $40.00 for a 61-100 day supply)

Alcoholism/Substance Abuse	
• Hospitalization for medical management of withdrawal symptoms.	No charge
• Individual Therapy	$15.00 per visit
• Group Therapy	$ 5.00 per visit
Mental Health Care	
• Up to 45 days of hospital care	No Charge
• Maximum 20 out-patient visits per calendar year, individual therapy and/or group therapy.	
• Individual Therapy	$15.00 per visit
• Group Therapy	$ 7.00 per visit
Up to 20 additional Group Therapy Visits (pre-approved)	$ 7.00 per visit
Emergency Services	
• In Southern California service area	
(a) in a Kaiser facility	$75.00, waived if admitted directly to hospital
(b) in a non-Kaiser facility	As specified in ***Your Health Plan Coverage***.
• Out of Southern California	As specified in ***Your Health Plan Coverage***.
Hearing Aids	
• One hearing aid per ear every 36 months	No charge

If any **Covered Person** is eligible for Medicare it is possible to elect Kaiser's "Senior Advantage" Plan meaning that their Medicare coverage is solely provided through Kaiser Permanente and that only Kaiser facilities are to be utilized. In the absence of making a "Senior Advantage" election, the additional premium surcharge will be added to the monthly deduction. There are nominal differences to the above Schedule of Benefits to the extent there are fewer services where co-payments are applicable or co-payments would be less than under **Plan A**.

DELTA DENTAL BENEFITS

The dental benefits provided by this **Plan** for those **Covered Employees**, and their **Covered Dependents**, who do not elect coverage under a prepaid dental plan are provided through a contract between the **Trust** and Delta Dental Plan of California.

Participating Dentists

When a **Covered Person** utilizes the services of a participating Delta Dental Plan Dentist, payment will be based on the Applicable Percentage of the lesser of the fee charged or the Dentist's accepted fee on file with Delta Dental Plan. Payment to a non-participating Dentist will be based on the Applicable Percentage of the lesser of the fee charged or the fee shown on the Table of Allowances which satisfies the majority of Delta Dental Plan participating Dentists.

There may be a difference in the amount of payment that will be covered by the Plan if the Dentist is not a participating Dentist of Delta Dental Plan. A directory of participating Dentists who are members of Delta Dental Plan can be secured from the Trust Office.

Eligible Expenses

Eligible Expenses are payable in accordance with the San Diego Electrical Health and Welfare Trust Plan Document. Dental expenses in excess of these standards are not covered. The Delta Dental Plan will pay for **Eligible Expenses** up to the maximums specified in the Schedule of Benefits.

Basic Services

The basic dental services provided by Delta Dental Plan are as follows:

1. Diagnostic procedures to determine required dental treatment.

2. Preventive prophylaxis (teeth cleaning) as part of an oral examination not more often than twice in any 12 month period, fluoride treatment, and space maintainers. However, if the **Covered Person** has had periodontal surgery or has had periodontal scaling and root planing in all four (4) quadrants of the mouth, and if the **Covered Person's** Dentist provides written certification that routine cleaning and scaling of the teeth is Dentally

Necessary to prevent periodontal disease, then charges for such cleaning and scaling is covered provided at least three (3) months have passed since the last cleaning and scaling for which benefits were payable by this **Plan**.

The **Plan** will also consider additional services as **Eligible Expense** for the purpose of improving the oral health of a **Covered Person** during their pregnancy. Said additional services shall consist of one additional oral exam and either one additional routine cleaning or one additional periodontal scaling and root planing per quadrant if provided during the **Covered Person's** pregnancy. Written confirmation of the pregnancy must be provided to the **Plan** by the **Covered Person** or her dentist in order for a claim for such additional services to be payable.

3. General anesthesia when administered by a Dentist for a covered oral surgery procedure.

4. Restorative treatment of tooth decay or fracture by amalgam, synthetic porcelain or plastic restorations. Crowns, jackets and cast restorations will be provided only when amalgam, synthetic porcelain or plastic restorations will not suffice.

5. Endodontic treatment of the tooth pulp.

6. Periodontic treatment of gums and bones supporting teeth.

7. Sealants may be applied to the teeth of a **Covered Person** under the age of 14 and only to permanent posterior molar teeth with no decay, no restorations and with the occlusal surface in tact. Coverage does not include the repair or replacement of a sealant on any tooth within 3 years of its application.

Prosthodontic Services

The Delta Dental Plan also provides procedures for the construction or repair of fixed bridges and partial or complete dentures.

Orthodontic Services

1. Orthodontics are defined as the procedure performed by a licensed Dentist, involving surgical repositioning of the teeth or jaws in whole or in part and/or the use of an active orthodontic appliance and post-treatment retentive appliances for the treatment of malalignment of teeth and/or jaws which significantly interferes with their function.

2. Delta Dental will pay or otherwise discharge 50% of the lesser of the Usual, Customary and Reasonable fees or the fees actually charged for orthodontics.

3. The lifetime maximum amount payable by Delta Dental for all orthodontic services rendered to each **Covered Person** shall be $1,500.00 and the limitations on maximum amounts payable during a calendar year, specified in the Schedule of Benefits on page 17 shall not apply to orthodontics.

4. Exclusions and Limitations specific to orthodontics:

    a. The obligation of Delta Dental to make payments for an orthodontic treatment plan begun prior to the eligibility date of the patient shall commence with the first payment due following the patient's eligibility date. The above-mentioned maximum amount payable will apply fully to this and subsequent payments;

    b. The obligation of Delta Dental to make payments for orthodontics shall terminate on the payment due date next following the date the **Dependent** loses eligibility or the **Employee** loses eligibility, or upon termination of treatment for any reason prior to the completion of the case, or upon termination of the contract with the **Trust**, whichever shall occur first;

    c. Delta Dental will not make any payment for repair or replacement of an orthodontic appliance furnished, in whole or in part, under this benefit; and

    d. X-rays and extraction procedures incident to orthodontics are not covered by the Orthodontic Services benefit, but may be covered under the provisions of Basic Services, subject to all terms, limitations and exclusions.

Service Limitations

The benefits provided by this Dental Plan are subject to the following limitations:

1. Complete mouth x-rays (at least 14 films) are provided only once in a 5-year period, unless special need is shown. Supplementary bitewing (individual) x-rays are provided if requested by a Dentist, but not more than once every 6 months for **Covered Dependents** under age 18, or once every 12 months for a **Covered Person** age 18 or older, while covered under the **Plan**;

2. Crowns, jackets and cast restorations will be replaced only after five years have passed since it was provided under any Delta Dental Plan program, unless Delta Dental determines an existing broken or fractured crown cannot be made satisfactory;

3. Prosthodontic appliances that were provided under any Delta Dental program, including but not limited to fixed bridges and partial or complete dentures, will be replaced only after 5 years have passed, unless Delta Dental determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory, including broken or fixed bridges or fractured crowns that are part of a fixed bridge. Replacement of a prosthodontic appliance not provided under a Delta Dental program will be made if it is unsatisfactory and cannot be made satisfactory;

4. Fixed Bridges and partial or complete dentures and related procedures are paid at 50% of the customary charge for a standard prosthodontic appliance regardless of special circumstances;

5. Selection of a more expensive treatment than is customarily provided, or specialized techniques rather than standard procedures, Delta Dental will pay the applicable percentage of the lesser fee and the **Covered Person** will be responsible for the remainder of his Dentist's fee; and

6. Implants or procedures related to the placement, replacement or removal of implants only upon the advance approval of a proposed plan of treatment submitted by a Delta Dental Plan Dentist which has been approved by a Delta Dental Consultant.

Schedule of Benefits

Payment of **Eligible Expenses** for dental services shall be subject to the following limitations:

1. Usual, Customary and Reasonable Expense (UCR). Up to the maximum of $2,000.00 per calendar year.

2. Basic Services. 80% for Non-DPO dentists or 90% for DPO dentists of the UCR fees or the fees actually charged, whichever is less, or 100% for preventive prophylaxis, x-rays or diagnostic procedures to determine required dental treatment performed by any Delta Dental provider who is currently a Delta Preferred Option (DPO) dentist.

3. Prosthodontic Service. 70% for Non-DPO dentists or 90% for DPO dentists of the UCR fees or the fees actually charged, whichever is less.

4. Crowns, Jackets, Inlays, Outlays and Cast Restorations. 80% for Non-DPO dentists or 90% for DPO dentists of the UCR fees or the fees actually charged, whichever is less.

5. Orthodontic Services. 50% for Non-DPO dentists or 75% for DPO dentists of the UCR fees or the fees actually charged, whichever is less, up to a lifetime maximum of $1,500.00. Benefits are payable as follows: 50% upon installation of the orthodontic appliance and the remaining 50% in quarterly installments.

For the purpose of this Section the term "fees actually charged" means the fees for a particular dental service or procedure which a participating Dentist reports to Delta Dental less any portion of such fee which is discounted, waived, rebated or which the Dentist does not attempt to collect in good faith.

Exclusions

1. Services for injuries or conditions which are compensable under Worker's Compensation or Employer's Liability Laws; services which are provided to the **Covered Person** by any Federal or State Government Agency or are provided without cost to the **Covered Person** by any municipality, county or other political subdivision, except as provided in Section 1373(a) of the California Health & Safety Code;

2. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth);

3. Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to: equilibration and periodontal splinting;

4. Prosthodontic services or any single procedure started prior to the date the person became eligible for such services under Delta Dental;

5. Prescribed drugs, pre-medication or analgesia;

6. Experimental procedures;

7. Prophylaxis, if the **Covered Person** has received two prophylaxes covered by **Delta Dental** in the immediately preceding eleven months, unless the additional prophylaxes were permitted in accordance with item 2 under Basic Services;

8. All hospital costs and any additional fees charged by the Dentist for hospital treatment;

9. Charges for anesthesia, other than general anesthesia administered by a licensed Dentist in connection with covered oral surgery services;

10. Extra-oral grafts (grafting of tissues from outside the mouth to oral tissue);

11. Implants (materials implanted into or on bone or soft tissue) or procedures related to the placement or removal of implants, except as may be provided under "Service Limitations";

12. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves and other tissues;

13. Replacement of existing restorations for any purpose other than restoring active carious lesions; and

14. Orthodontic services (treatment of malalignment of teeth and/or jaws), except as otherwise provided for under Orthodontic Services.

How to Use the Delta Dental Plan

1. **Attending Dentist's Statement**. To obtain dental benefits, each Dentist should obtain an Attending Dentist's Statement from Delta Dental Plan.

2. **Predetermination of Fees**. After the initial examination, each Dentist will determine the treatment to be performed. The Dentist must submit an Attending Dentist's Statement to Delta Dental Plan. Delta Dental Plan will determine if the proposed treatment is covered under this Dental Plan and the amount to be paid towards the cost of such treatment.

3. **Review of Fees**. After the Attending Dentist's Statement is returned to the Dentist, he will review the amount to be paid under this Dental Plan with the **Covered Person** and the amount of his obligation.

4. **Independent Review**. Delta Dental Plan may require, as a condition of payment for services, that reasonable evidence of the extent and character of services be submitted or that the **Covered Person** be examined by an independent dental consultant.

SECTION XVII. VISION BENEFITS

Vision care benefits are provided through a contract between the **Trust** and Vision Service Plan (VSP). If a **Covered Person** chooses to go to a VSP panel **Physician**, VSP shall pay for the following basic vision services. Any additional care, service and/or materials not covered by VSP must be arranged between the **Covered Person** and his **Physician** or Optometrist.

Basic Services
The basic vision services provided by VSP are as follows:

1. **Vision Examination**. Complete analysis of the eyes and related structures to determine the presence of vision problems, or other abnormalities, once each calendar year. However, if a **Covered Person** has been diagnosed with Type I diabetes they shall be entitled to a second examination each calendar year provided it is separated by at least six (6) months from their last examination.

2. **Lenses**. One pair each calendar year only if required due to a change in prescription.

3. **Frames**. One pair each calendar year.

4. **Contact Lenses**. Allowance of $110.00 for one pair of contact lenses, chosen in lieu of lenses and a frame, each calendar year. Contact lenses are covered in full if considered **Medically Necessary** and prescribed to correct extreme vision acuity that cannot be corrected with spectacle lenses, following cataract surgery or for treatment of certain conditions of Anisometropia or Keratoconus.

Deductibles
The following deductibles are applicable to certain Basic Services:

1. Vision Examination - $10.00 per **Covered Person** for each examination performed by a VSP panel **Physician**.

2. Lenses/Frames - $15.00 per **Covered Person**. This deductible shall not be applicable to the purchase of elective contact lenses.

The above deductibles are payable at the time services are rendered and/or lenses/frames are ordered.

Additional Services
In instances where a **Covered Person** purchases a second pair of glasses from the same VSP panel **Physician** from whom the initial pair was purchased, which is **not** covered under Basic Services, the **Physician** will apply a discount of no less than 20% to the retail cost of all such materials.

Low Vision Benefit
Low Vision Benefits to **Covered Persons** who have severe visual problems that are not correctable with regular lenses are provided by VSP, subject to prior approval by VSP consultants, as follows:

1.	**Supplementary Testing**:	VSP Panel **Physician**	---	Covered in full
		Non-Panel	---	Non-Panel Benefit*
2.	**Supplemental Care**:	VSP Panel **Physician**	---	75% of cost
		Non-Panel	---	Non-Panel Benefit*
3.	**Co-payment**:	25% of the authorized benefits payable by VSP.		
4.	**Maximum Benefit**:	$1,000.00 payable by VSP every 24 month period.		

*Non-Panel Benefit: Low vision benefits secured from a Non-panel **Physician** are subject to the same maximum fee allowances, time limits and co-payment arrangements as for VSP panel **Physicians**. However, there is no assurance the **Covered Person's** liability will not exceed 25% of total charges billed by a non-panel **Physician**.

Service Limitations

The vision services provided by VSP are subject to the following limitations or exclusions:

1. Orthoptics or vision training and any associated supplemental testing, plano lenses (non-prescription), two pair of glasses in lieu of bifocals or glass secured when there is no vision change;

2. Lenses and frames furnished under this Plan which are lost or broken will not be replaced except at the normal intervals when services are otherwise available;

3. Medical or surgical treatment of the eyes;

4. Any eye examination or any corrective eye wear required by a **Contributing Employer** as a condition of employment;

5. The additional cost of optional cosmetic processes or materials such as, but not limited to, UV protected lenses, blended or progressive multifocal lenses, oversize lenses, photochromic or tinted lenses other than pink 1 or 2, coating or laminating of lenses or frames costing more than the Plan allowance;

6. Contact lenses (except as noted elsewhere herein); and

7. Certain limitations on low vision care.

VSP may, at its discretion, waive any of the above limitations if, in the opinion of VSP's Optometric Consultants, it is necessary for the visual welfare of the **Covered Person**.

Non-VSP Provider Indemnification

If a **Covered Person** elects to utilize a non-VSP **Provider** he may secure services from any Optometrist, Ophthalmologist and/or dispensing Optician and this Plan becomes an indemnity plan. The **Covered Person** using the services of a non-VSP **Provider** should pay the **Physician** his full fee, while then being reimbursed by VSP according to the Schedule of Benefits provided below. There is no assurance that these allowances will be sufficient to pay for the examination or materials.

The maximum allowance, after deductibles, for expenses incurred is as follows:

1. **Vision Examination**	Up to-		$ 50.00
2. **Materials**		(Per Pair)	
Single Vision Lenses	Up to-		$ 45.00
Bifocal Lenses	Up to-		$ 70.00
Trifocal	Up to-		$ 90.00
Lenticular Lenses	Up to-		$140.00
Frames	Up to-		$ 65.00
3. **Contact Lenses**			
Necessary	Up to-		$210.00
Elective	Up to-		$110.00

How to Use the Vision Care Plan

1. **Appointments**. The **Covered Person** may select a VSP panel **Physician** from a list of VSP panel **Physicians** in the local area and make an appointment. The VSP panel **Physician's** office will call VSP to verify eligibility and benefits.

2. **Additional Services**. The **Covered Person** must pay for any additional services received, which may be subject to scheduled VSP discounts.

3. **Emergency Care**. In emergency cases when immediate vision care is needed, a **Covered Person** can obtain covered services by contacting a VSP panel **Physician** directly. The VSP panel **Physician** will call VSP to verify eligibility and VSP will mail the benefit form directly to the VSP panel **Physician**.

MEMBERS' ASSISTANCE PROGRAM ("MAP")

Each Covered Person under **Trust Medical Benefits** or a Prepaid Medical plan shall be entitled to up to 8 sessions of evaluation and/or counseling in any 12-month period by a professional counselor through an Agreement between the Trust and Horizon EAP. Under **Trust Medical Benefits** only if it is determined that further treatment of a **Psychiatric Condition** is necessary, either **in-patient** or **out-patient**, then a referral will be made to MHN. Subject to the Claim Review Procedures of this **Plan** the terms of the Agreement shall control the eligibility for and the providing of benefits to all **Covered Persons**.

MHN

An exclusive Agreement has been entered into between the **Trust** and MHN to provide comprehensive coverages for both **in-patient** and **out-patient** treatment of mental health and **Psychiatric Condition(s)** related claims. Except as otherwise stated in this **Plan**, such services may only be secured from MHN, subject to referral by Horizon Health (formerly Integrated Insights), and in accordance with the following Schedule of Benefits:

MENTAL HEALTH & CHEMICAL DEPENDENCY TREATMENT
SCHEDULE OF BENEFITS

In-Network benefits for other than emergency treatment require an initial assessment by the Members' Assistance Program, who will then seek pre-authorization from MHN.

Out-of-Network services of any kind will only be covered if due to an emergency.

	In Network
Lifetime Maximum	Unlimited
Chemical Dependency Treatments	2 treatments within 5 years
Inpatient MH/CD	
• ***Severe Mental Illness***	***Unlimited***
• All Other Diagnoses	30 Days
Inpatient Co-Pay	
• Days 1 - 5	$25/Day
• Days 6 - 30	$50/Day
RTC/CDRH Co-Pay	**In Network**
	$25/Day
PDT/SOP/IOP Co-Pay	
Outpatient MH/CD	$0/Day
• ***Severe Mental Illness***	***Unlimited***
• All Other Diagnoses	30Visits
Outpatient Co-Pay	
• Visits 1 - 30	$15/Visit
Group Therapy Co-pay	$10/Visit

CD=Chemical Dependency
CDRH=Chemical Dependency Recovery Hospital
MH=Mental Health
RTC=Residential Treatment Center
PDT=Partial Day Treatment
IOP=Intensive Outpatient Program
Dual Coverage=Doubles the number of days/visits
SOP=Structured Outpatient Program

Subject to the Claim Review Procedures of this **Plan**, the terms of the Agreement shall control the eligibility for and the providing of benefits to all **Covered Persons**.

HOME HEALTH CARE

Benefits are payable for reasonable and customary expenses incurred by a **Covered Person** under a certified Home Health Care program, prescribed through Case Management of the Intracorp, which commences within 7 days following the termination of a **Hospital** confinement, unless otherwise determined through Case Management.

A Home Health Care agency means: (a) a **Hospital** possessing a valid operating certificate issued in accordance with a public health law, or law of a similar intent, authorizing the **Hospital** to provide Home Health Care services; or (b) a Home Health Care service organization or agency possessing a valid certificate issued in accordance with such public health law, or similar legally valid credential, authorizing such organization or agency to provide Home Health Care services.

The Home Health Care treatment program must be established in writing by a **Physician** and approved by Case Management. The **Physician** must also certify that the medical condition would, in the absence of the Home Health Care benefits, require confinement in a **Hospital** or **Skilled Nursing Facility**.

Eligible Expenses include:

A. Part-time or intermittent nursing care by or under the supervision of a registered professional nurse (R.N.).

B. Part-time or intermittent Home Health aide services which consist primarily of caring for the patient.

C. Physical therapy for rehabilitative purposes only, prescribed by a **Physician** and administered at least once per week, if the **Covered Person** is confined to his residence following an accident or illness and is unable to receive such treatment on an **out-patient** basis.

The following expenses are not eligible Home Care Health expenses:

A. Expenses for services of a person who resides in a **Covered Person's** home or is a member of that family.

B. Expenses for services and supplies not related to necessary medical care or treatment.

C. Expenses for services rendered while a **Covered Person** are not under the continuing care of a **Physician**.

D. Expenses for **Custodial Care** and transportation services.

HOSPICE CARE

Intent

This coverage provides reimbursement for specific expenses incurred by a **Covered Person** who is enrolled in an approved Hospice Program as prescribed through Case Management. These benefits are meant to cover 80% of the reasonable and customary charges for those expenses emanating from the specific needs of an individual enrolled in such a program in accordance with the Schedule of Benefits.

The following services will be considered eligible if prescribed through Case Management, approved by the patient's attending **Physician** and billed through the approved Hospice:

Eligible Expenses

Room and Board--When a Hospice patient is confined to an approved Hospice facility located within a **Hospital**, the benefit will be limited to that **Hospital**'s most common semi-private room and board charge. When a **Covered Person** is confined to an approved free-standing, **in-patient Hospital** facility, the **Plan** will reimburse that **Covered Person** for the daily room and board charge, up to a predetermined daily room and board benefit, subject to the overall **Plan** maximum, where applicable. (The daily benefit will not exceed the most common semi-private room and board charge for **Hospitals** in the immediate geographic area.)

Skilled Nursing and Home Health Aide--An individual will be reimbursed for **Skilled Nursing** or Home Health Aide services, provided they are deemed necessary by Case Management, the Hospice and the **Covered Person's** attending **Physician**. In order for benefits to be payable, the services must be provided by either a Registered Nurse or a Licensed Practical Nurse.

Physical, Respiratory and Speech Therapy--Expenses incurred for the above treatments are covered if they are approved by Case Management, the **Covered Person's** attending **Physician** and the Hospice.

Other Services--Any other services provided through the Hospice Program are covered if deemed **Medically Necessary** by Case Management and the **Covered Person's** attending **Physician**. These include, but are not limited to: medical supplies, medicines, drugs, **Physician** services and rental of short-term **Durable Medical Equipment**.

All of the above services must be part of, as well as billed through, the approved Hospice Program at which the **Covered Person** is enrolled in order to be considered eligible.

Exclusions and Limitations

The following services will not be considered eligible Hospice Care expenses:

A. Any volunteer services or services which would normally be provided free of charge;

B. Services provided in the areas of both legal and/or financial advice (preparation and execution of wills; estate planning and liquidation; financial investment, etc.);

C. Counseling by clergy or any volunteer group;

D. Services of a person who ordinarily resides in the home of the terminally ill individual or member of his/her family or **Spouse's** family; or

E. Any services not both provided and billed through the Hospice Program and approved by Case Management and the **Covered Person's** attending **Physician**.

LIFE INSURANCE BENEFITS

Life insurance benefits are provided to all **Covered Employees** through a contract between an insurance carrier and the **Trust**. Upon receipt of proof of the death of the **Covered Employee** the life insurance carrier selected by the **Trustees** shall pay the applicable amount of basic life insurance and/or accidental death and dismemberment coverage specified in the Schedule of Benefits and any additional amount purchased by the **Covered Employee** in the form of supplemental life insurance benefits in effect at the time of his death. Any sum(s) payable as a death claim shall be paid in accordance with the terms of such policy, subject to the Claim Review Procedures contained in this **Plan**.

If a **Covered Employee** is age 70 or older at the time he first became eligible under **Plan A**, he will not be eligible for the basic or supplemental life insurance benefits provided by this **Plan**. The benefit amount for each **Covered Employee** reduces on the 65th and 70th birthday to 65% and 50%, respectively, of basic life amount in effect as of the day before their 65th birthday.

If a **Covered Employee** becomes **Totally Disabled**, as defined in the policy, prior to age 65, the basic life insurance benefit will be continued at no cost to the **Covered Employee** so long as he remains **Totally Disabled** or until his 70th birthday. Accidental Death and Dismemberment Benefits, however, will terminate when the **Covered Employee** becomes **Totally Disabled**. Proof of **Total Disability** must be submitted to the **Trust's** Administrative Manager and approved by the insurance carrier, subject to the Claim Review Procedures contained in this **Plan**.

SUPPLEMENTAL LIFE INSURANCE BENEFITS

In addition to the basic life insurance coverage, optional supplemental term life insurance is also available to **Employees** covered under **Plan A**. **Covered Employees** who are under age 70 may apply to the insurance carrier for the following benefit amounts during each annual enrollment period:

Covered Employee:	Benefit amounts are $25,000, $40,000, $100,000 or $200,000; and
Covered Spouse:	Benefit amounts are $10,000, $20,000 or $50,000 and are limited to 50% of the **Covered Employee's** supplemental term life benefit; and/or
Covered Child(ren):	$10,000 per child at least 6 months of age. A benefit of $1,000 is applicable to children between 15 days and 6 months of age.

Guaranteed Issue - Applicants who are under age 60 and apply for the following optional supplemental term life insurance benefit amounts during the annual enrollment period immediately following the date the applicant first becomes covered by this **Plan** are not required to complete a medical questionnaire, nor can their application be denied by the carrier:

Covered Employee:	$25,000 and $40,000;
Covered Spouse:	$10,000 and $20,000; and
Covered Child(ren):	$10,000 per **Child**.

Effective Date of Supplemental Life Insurance Coverage - It will be possible to apply for any of the above supplemental term life options only in conjunction with the annual enrollment period. All timely applications for benefit amounts which are not subject to approval by the insurance carrier will become effective January 1st of each year. All other applications will become effective the later of the January 1st following the annual enrollment period or the first day of the month following the Trust Office's receipt of the insurance carrier's approval.

In no event will any supplemental term life insurance coverage go into effect if, on the date such coverage is to become effective, the **Covered Person** is **Disabled**. This restriction will remain in effect until the **Covered Person** is no longer **Disabled**. Further, this restriction is applicable even if the insurance carrier had previously approved the **Covered Person's** application for a non-guaranteed issue benefit.

Premium - The premium charge for each form of supplemental term life insurance will be converted to a cost, in hours-per-month, which will be added to the **Covered Employee's** monthly cost of coverage for as long as such coverage remains in effect.

(a) Premiums for **Employees** and **Spouses** are calculated by applying the insurance carrier's cost per $1,000 for each designated age bracket.

(b) The premium for children's coverage is a flat amount, regardless of the number of **Dependent Children** to be covered.

To the extent required by law, the imputed value of supplemental group term life insurance exceeding $40,000 for the **Covered Employee** and all such coverage for **Covered Spouse's** and/or **Covered Children** will be considered taxable income to the **Covered Employee**.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If a **Covered Employee** suffers **Accidental Bodily Injury**, directly and independently of all other causes, which results in any of the specific losses described below within 365 days after the date of the accident causing the loss, the insurance carrier selected by the **Trustees** shall pay the benefits set forth below, subject to the limitations and provisions of the policy. Written proof of loss must be filed with the Trust Office or insurance carrier within 90 days from the date the **Employee** becomes aware of such a loss. If more than one such loss is sustained as a result of the accident, payment shall be made for only the one loss for which the largest amount is payable, and no loss sustained prior to such accident will be included in determining the amount payable.

A. **Accidental Death**. For loss of life, the Principal Sum amount specified in the Schedule of Benefits is payable to the designated Beneficiary.

B. **Dismemberment**. Benefits for dismemberment are payable by the insurance carrier subject to the limitations and provisions of the policy, for any injury occurring on or off the job within 365 days of the accident as follows:

1. The Principal Sum specified in the Schedule of Benefits is payable for the loss of: both hands; both feet; one hand and one foot; one hand or one foot and the sight of one eye; the sight of both eyes; or loss of speech and hearing.

2. One-half of the Principal Sum specified in the Schedule of Benefits is payable for the loss of one hand or one foot, the entire sight of one eye; or loss of speech or hearing.

3. One-quarter of the Principal Sum specified in the Schedule of Benefits is payable for the loss of the thumb and index finger of the same hand.

Definitions. Loss of sight means entire and irrecoverable loss of sight. Loss of a hand means severance of the hand at or above the wrist. Loss of a foot means severance of the foot at or above the ankle. Loss of a thumb and index finger means the severance of both through or above metacarpophalangeal joints. Loss of speech means entire and irrevocable loss of speech. Loss of hearing means entire and irrevocable loss in both ears.

C. **Paralysis Benefit**. Benefits for the following types of paralyzes, resulting from an injury to a **Covered Person** which commences within 365 days of the date of the accident which caused the injury, the insurance carrier will pay the percentage of the principal sum shown below:

Paralysis	Percentage of Principal Sum
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Uniplegia	25%

Definitions. Quadriplegia means the complete and irreversible paralysis of both upper and lower limbs; Paraplegia means the complete and irreversible paralysis of both lower limbs; Hemiplegia means the complete and irreversible

paralysis of upper and lower limbs of one side of the body; Uniplegia means the complete and irreversible paralysis of one limb; Limb means an entire arm or entire leg.

If the **Covered Person** suffers more than one type of paralysis as a result of the same accident, only the largest of the benefits payable for injuries pertaining to that accident will be paid.

Further, the amount of this benefit will be reduced by any amount paid for accidental dismemberment under the policy to or on behalf of the **Covered Person** as a result of the same accident.

D. **Coma Benefit**. When injury renders a **Covered Person** comatose within 90 days of the date of the accident which caused the injury, and such coma has continued for a period of 12 consecutive months, the insurance carrier will pay the principal sum less any amount paid or payable to or on behalf of the **Covered Person** under the policy as the result of the same accident, at the rate of 1% per month for 100 months.

Definition. Coma/comatose, for the purpose of this benefit, means a profound state of unconsciousness from which the **Covered Person** cannot be aroused to consciousness, even by powerful stimulation, as determined by a **Physician**.

E. **Seat Belt Benefit**. The insurance carrier will pay a benefit of an additional 10% of the principal sum, up to a maximum of $10,000., if the **Covered Person** suffers accidental death such that an accidental death benefit is payable, for an accident occurring while operating or riding as a passenger in a private passenger automobile and the **Covered Person** was wearing a properly fastened, original, factory-installed seat belt.

Verification of the actual use of the seat belt, at the time of the loss, must be part of an official report of the accident or certified in writing by the investigating officer(s).

Limitations. Total payment for any one accident may not be more than the full amount of the basic life insurance coverage. The loss must take place within 365 days of the accident. No benefits shall be payable if the **Covered Employee's** loss shall directly or wholly result from: (1) intentionally self-inflicted injury or suicide; (b) bacterial infections (except pyogenic infections occurring simultaneously with and in consequence of **Bodily Injury** for which accidental death or dismemberment benefits are payable); (c) bodily or mental infirmity, disease of any kind, or as a result of medical or surgical treatment therefor; (d) hernia of any kind; (e) war, whether declared or undeclared, or insurrection; or (f) travel or flight as a pilot or crew member in any kind of aircraft.

PLAN A ELIGIBILITY

ELIGIBILITY FOR BARGAINING EMPLOYEES UNDER PLAN A

ARTICLE I. ELIGIBILITY RULES

Employees of **Contributing Employers**, and their eligible **Dependents**, who work within the jurisdiction of and under the terms of the collective bargaining agreements creating the San Diego Electrical Health and Welfare Trust, and are presently covered in **Plan A**, will remain covered in accordance with Article II. All other **Employees**, and their eligible **Dependents**, will become covered in accordance with the terms outlined in Article III.

In the event a **Bargaining Employee** dies after accruing 260 hours within a twelve month period or less, and prior to the date his coverage would otherwise have taken effect, coverage for the **Bargaining Employee** only shall be deemed to have commenced as of the **Bargaining Employee's** last day of work.

Further, if the **Bargaining Employee** is age 70 or older as of the effective date of his initial coverage as a **Plan A** participant, he will not be eligible for any life insurance benefits provided by or available through the **Plan**.

ARTICLE II. CONTINUED ELIGIBILITY

The employment records of all **Bargaining Employees** will be reviewed on a monthly basis to determine whether a **Bargaining Employee** is eligible for continued coverage by satisfying their minimum hourly requirement for the appropriate cost of coverage based on the type of coverages, in effect at the time, as elected by the **Employee**. Each **Bargaining Employee** will remain covered through the third month following that month in which the minimum hourly requirement is

satisfied by virtue of any combination of hours worked for **Contributing Employers** and/or existing in his Reserve Account (see Article VI.). However, any **Bargaining Employee** who becomes employed by a Non-**Contributing Employer** will not be permitted to remain covered as of the end of the month in which such employment commenced. In such an event, all hours existing in his Reserve Account as of the last day of said month shall be frozen in accordance with Article VI. In such an instance the only basis for continuing coverage will be in accordance with the Rules for Continuation Coverage Following Termination under COBRA.

The minimum hourly requirement for **Trust Medical Benefits** with basic life insurance, Delta Dental and Vision Service Plan benefits is 140 hours per month. The hourly requirement for coverages consisting of supplemental life insurance benefits or Kaiser medical benefits may differ, depending upon the combination of benefits elected by the **Bargaining Employee**, and the **Bargaining Employee** will be charged or credited accordingly.

ARTICLE III. INITIAL ELIGIBILITY

New **Bargaining Employees** are defined as those who are not presently eligible for coverage under **Plan A** in accordance with Article I. A New **Bargaining Employee** will become eligible on the first day of the second month following the month in which a minimum of 260 hours have been reported in his name by **Contributing Employers** during any twelve consecutive calendar months, or less. However, hours reported by a **Contributing Employer** which had already been credited toward a month of coverage may not be included in satisfying the minimum hours requirement for Requalification under this Article.

The coverage of a newborn dependent **Child** shall take effect on the date of birth, adoption or placement for adoption of such **Child**; however, such coverage for routine nursing care or well-baby care, immunizations, examinations or tests not connected with injury, illness, congenital defects or birth abnormalities shall be payable in accordance with the Schedule of Benefits or under **Eligible Expenses** until the **Child** attains the age of 26.

Newly organized Employers and Employees:

Employers - **Bargaining Employees** of newly organized Contributing **Employers** who have provided evidence of existing health coverage with such **Employer** as of the date of execution of a Collective Bargaining Agreement with IBEW Local 569, shall become covered under this **Plan** effective the first day of the month following termination of the **Contributing Employer's** existing group health insurance policy. In addition, newly organized employees who have group health insurance coverage under their prior employer in effect on the date their work in **Covered Employment** commences, shall also be eligible for immediate coverage under this **Plan**. To be eligible for such coverage the following requirements must be satisfied:

(a) **Employees** of newly organized **Contributing Employers**, the **Employee** must have worked at least 125 hours per month for each of the three months prior to the Employer's execution of the Collective Bargaining Agreement; and

(b) Newly organized employees must present proof of prior group health insurance coverage by their former employer to the Administrative Manager of the Trust. Coverage for such employees shall commence as of the date they commence work in Covered Employment.

(c) Coverage shall begin on the first day of the month following execution of the Collective Bargaining Agreement. Pursuant to the coverage afforded by this provision, the **Covered Employee** and his or her eligible **Dependents** will participate in **Plan A** Trust Medical Benefits (PPO). Following the initial three months of participation in **Plan A**, the Employee may be afforded the same initial benefit options available to all newly covered Participants provided the **Employee** worked at least 280 hours in their first two months of participation in the **Plan**.

(d) In the event a **Covered Employee** subject to this provision terminates employment, whether voluntary or involuntary, prior to establishing eligibility in the **Plan** (before the end of the initial three months of participation), all benefits under this **Plan** will immediately terminate. However, if the **Employee** immediately signs the out-of-work book at IBEW Local 569 and returns to work for a signatory **Employer**, without having worked at the trade for a non-signatory employer, the **Employee's** initial three month period will be reinstated retroactive to the date of their latest termination from coverage. The **Contributing Employer** and the **Covered Employee** shall be required to provide the Trust Office with immediate written notification of an **Employee's** termination of employment during the initial three month period. In the event of a termination of employment

within the initial three months of participation in the **Plan,** the Employee's Reserve Account shall also be terminated.

Employees - Bargaining Employees organized by Local 569 who have provided evidence of existing health coverage as of the date they become a member of IBEW Local 569 shall become covered, along with all eligible dependents, on the date their work in Covered Employment commences. Under no circumstances will any newly organized **Bargaining Employee** be granted more than one opportunity for immediate coverage under these Eligibility Rules.

Each **Bargaining Employee** eligible for the initial three months of immediate coverage will receive a credit to their Reserve Account equal to three months of the then current cost of coverage for Trust Medical Benefits. Upon the Employee satisfying the minimum eligibility requirement under the Rules of Eligibility for **Bargaining Employee**s Under **Plan A** all hours reported each month in excess of the Employee's monthly cost of coverage, which would otherwise accumulate in their Reserve Account, will be applied to offset the initial allocation of Reserve Account hours. Once the advanced Reserve Account hours have been recovered, all excess hours will be retained in the Employee's Reserve Account to be applicable to future coverage.

ARTICLE IV. TERMINATION

A review of the hours reported for each **Bargaining Employee** will be made on a monthly basis. Eligibility for the **Bargaining Employee**, and his **Covered Dependents**, will terminate if the **Bargaining Employee** has not accumulated a minimum of 140 hours during the corresponding work month described in Article II. or, if applicable, the minimum hourly requirement commensurate with the appropriate cost of the **Employee's** Coverage. Notwithstanding the provisions of Article II., or any other Articles of these Rules of Eligibility, an **Employee** otherwise eligible for coverage shall be immediately terminated as a **Covered Employee** if that person is no longer employed by, or available for full-time work by, a **Contributing Employer**, except this condition shall not apply to any **Employee** who cannot work due to a **Disability** or retirement. A person shall be presumed to be unavailable for full-time work by a **Contributing Employer** if that person is employed full-time performing work at the trade for a Non-**Contributing Employer**.

The coverage of the **Covered Person** shall terminate: (1) on the date the **Covered Person** ceases to be eligible for coverage; (2) on the date the **Covered Person**, if a **Dependent**, ceases to be a **Dependent**; (3) upon the **Covered Person** failing to make any necessary **Direct Payment** by the due date; (4) upon the death of the **Covered Employee**; (5) upon termination of the **Plan;** or (6) if it is determined that coverage became effective due to a fraudulent or intentional misrepresentation of material facts or information that would otherwise have prevented the Covered Person from becoming covered under the Plan.

In the event a retired **Covered Employee**, or their **Dependent Spouse,** has remained covered through the use of post-retirement hours and becomes entitled to Medicare, their individual coverage in the **Plan** will terminate effective with the first day of the month their Medicare coverage becomes effective. If the retired **Employee's** Medicare entitlement precedes that of their **Spouse**, this will constitute a qualifying event for their **Spouse** in accordance with the Rules for Continuation Coverage Following Termination under COBRA.

However, when a retired **Covered Employee's** primary residence falls outside any geographic area where current Plan C Kaiser coverage is generally available, if the retired **Covered Employee** qualified for subsidized Plan C deductions at the time their pension benefit commenced then they will be entitled to receive the same amount of monthly subsidy afforded to a Medicare eligible Plan C participant receiving the same amount of pension benefit upon submission of a receipt confirming their payment of a Medicare supplemental premium.

ARTICLE V. RE-QUALIFICATION

An **Employee** whose eligibility has been terminated may only re-qualify for coverage as a New Employee in accordance with Article III. However, a retired **Employee** who engages in permitted post-retirement employment may not use those hours to qualify for Plan A coverage or to reinstate Plan A coverage that had been terminated prior to or at any time after the effective date of their monthly benefit from the San Diego Electrical Pension Trust. All contributions received for such post-retirement employment shall be recognized as **Plan C** contributions and may only be utilized if the **Retiree** and/or their **Spouse** become covered under **Plan C** in accordance with the Rules of Eligibility For **Retirees** Under **Plan C**.

In the event a former **Covered Employee** has retired, but performs post-retirement employment as permitted by the San Diego Electrical Pension Plan Document, if their **Plan A** coverage has not been continuous since the date of their retirement they will not be permitted to re-qualify for **Plan A** coverage so long as they continue receiving monthly payments from the San Diego Electrical Pension Plan.

ARTICLE VI. RESERVE ACCOUNT

Once a **Bargaining Employee** has established his initial eligibility for coverage under Article I., he may accumulate hours in his Reserve Account by virtue of the amount of hours reported by **Contributing Employers** on a monthly basis to the extent that his reported hours in a given month exceed his cost of coverage for the corresponding month of coverage up to a maximum of 1,000 hours. Any accrued Reserve Account hours in excess of the maximum will revert to the **Trust**.

In accordance with Article IV. a charge against each **Bargaining Employee's** Reserve Account will be made, if necessary, to satisfy the cost of coverage for the appropriate month of coverage. In the event the combined total of hours reported by **Contributing Employers** and/or existing in the Reserve Account is insufficient to cover the cost of coverage, then all such hours may be credited against said cost of coverage and the balance may be paid in the form of a **Direct Payment** as provided in Article VII. If the **Bargaining Employee** fails to remit the **Direct Payment** on a timely basis, then all such hours shall revert to his Reserve Account to be used only upon satisfaction of Initial Eligibility in accordance with Article III.

Notwithstanding the provisions of this Article, a **Bargaining Employee's** Reserve Account shall be frozen if the person is no longer employed by or available for full-time work for a **Contributing Employer**, except this condition shall not apply to any **Bargaining Employee** who cannot work due to a **Disability** or retirement. A person shall be presumed unavailable for full-time work by a **Contributing Employer** if that person is either self-employed, employed part-time or full-time at any occupation for wages or profit for other than a **Contributing Employer** or is not enrolled and eligible for work on the "out-of-work" book of the **Union**. In the event a **Bargaining Employee's** Reserve Account is frozen in accordance with Articles III. and IV., and he does not re-qualify for coverage in accordance with Article V. of these Rules within 12 calendar months from the first day of the month in which his Reserve Account hours were frozen, all such hours shall be forfeited.

ARTICLE VII. DIRECT PAYMENTS

Direct Payments shall be made in such amounts and manner as prescribed by the **Trustees**. Each **Bargaining Employee**, upon being terminated from coverage in accordance with Article IV., shall be permitted to remit **Direct Payments** as a means of maintaining coverage for himself and his **Covered Dependents** for each month he failed to satisfy the applicable cost of coverage provided, however, that the **Employee** worked at least 1 hour for a **Contributing Employer** in the corresponding work month.

In the event the **Employee** fails to work at least 1 hour for a **Contributing Employer** in the corresponding work month the only means of maintaining coverage for himself and his **Covered Dependents** will be through the use of any Reserve Account hours and/or pursuant to the Rules for Continuation of Coverage Following Termination under COBRA. However, in the further event the **Employee** completes twelve consecutive calendar months
without receiving credit for at least 50 hours of **Covered Employment** the twelve corresponding **Direct Payments** will be recognized as being the first twelve payments under COBRA.

All Reserve Account hours will first be credited in determining the continued eligibility prior to acceptance of a **Direct Payment**. In the event a **Bargaining Employee** fails to make the required **Direct Payment**, eligibility will be terminated, all applicable Reserve Account hours will revert back to the **Employee's** Reserve Account, and the **Bargaining Employee** may only re-qualify his eligibility as a New **Bargaining Employee** in accordance with Article III.

All **Direct Payments** are due to be received by the Trust Office by the 15th day of the month for which coverage has been terminated, and in no event later than 30 days after the first day of said month.

Notwithstanding the provisions of this Article, no **Direct Payment** shall be allowed if the **Bargaining Employee** is no longer employed by, or available for full-time work by, a **Contributing Employer**, except this condition shall not apply to any **Bargaining Employee** who cannot work due to a **Disability.** A **Bargaining Employee** shall be presumed to be unavailable for full-time work by a **Contributing Employer** if that **Employee** is not enrolled and eligible for work on the "out-of-work" book of the **Union** and/or is employed full-time performing work at the trade for a Non-**Contributing Employer**.

ARTICLE VIII. DISABILITY

For the purpose of maintaining eligibility in accordance with Article II, a **Bargaining Employee** who has become **Disabled** while covered by this **Plan**, and who is not eligible for coverage under **Plan C**, may receive Disability Credit for each Month of Proven **Disability** for up to a maximum of 12 months, subject to the following conditions:

(a) The **Bargaining Employee** must have been continuously covered in **Plan A or Plan B** for at least the twelve (12) consecutive months prior to the onset of their **initial period of Disability** and initially sustain at least 30 consecutive days of **Disability** prior to becoming eligible to receive any Disability Credit.

(b) In the event a **Bargaining Employee** becomes **Disabled** their Reserve Account will be frozen, except as provided in item (c) until he/she is no longer eligible to receive Disability Credits or they have received the maximum number of Disability Credits.

(c) If the hours existing in the Reserve Account during the initial 30 days of **Disability** are insufficient to cover his cost of coverage, the **Bargaining Employee** must pay the balance in the form of a **Direct Payment** in order to maintain continuous coverage. This requirement will continue until the application of the first month of Disability Credit toward the cost of coverage for the first month of proven **Disability**.

(d) Once the initial 30-day period of disability is satisfied a month of proven **Disability** shall be any calendar month during which the **Bargaining Employee** is **Disabled** for at least 20 calendar days. However, the first month of disability credit may be no earlier than the first calendar month following the month in which the 30-day period of disability commenced.

(e) The **Bargaining Employee** shall receive Disability Credit for each month of proven **Disability** in the amount necessary to satisfy the hourly requirement of the cost of coverage which he had previously elected or may elect in a subsequent Annual Enrollment process. However, in the event the **Disability** continues longer than 12 consecutive months, or upon any termination from coverage in accordance with these Disability Rules, the **Bargaining Employee** shall be entitled to elect COBRA coverage under the Rules for Continuation Coverage Following Termination under COBRA for the remaining period of COBRA coverage.

(f) A period of **Disability**, for the purposes of this Article, shall be continuous unless the **Bargaining Employee** is no longer **Disabled** and returns to full-time employment in any occupation for wages or profit or if a subsequent **Disability** whose onset occurs after the Bargaining Employee returns to full-time employment is totally unrelated to the previous **Disability** for which Disability Credit was awarded.

For the purposes of this Article the term “full-time employment” shall mean the **Bargaining Employee** has been cleared by their attending **Physician** to resume the regular duties of their job and the **Employee** completes five (5) consecutive regularly scheduled days or 40 consecutive hours of regularly scheduled work.

(g) A **Bargaining Employee** may only qualify to receive up to a maximum of twelve months of Disability Credit under Plan A and/or Plan B, regardless of the number of periods of Disability that may occur. However, the Employee may again become eligible to qualify for a new maximum period of Disability Credit by being covered under either Plan A or Plan B for at least twelve (12) months subsequent to the last month for which Disability Credit was received.

(h) In the event a **Bargaining Employee** who is receiving Disability Credit under this Section returns to any occupation for wages or profit for other than a **Contributing Employer** then any previously frozen Reserve Account hours in accordance with item (b) above will be immediately forfeited and their coverage will be terminated as of the first day of the month following the month in which they engaged in such employment regardless of any Disability Credit that may have been previously earned that would have applied to continued coverage for that month or thereafter.

Each month of continuous coverage maintained by Disability Credit shall be considered one month of COBRA coverage and be applicable to the maximum period of COBRA coverage to which the **Bargaining Employee** may otherwise be entitled under the Rules for Continuation Coverage Following Termination under COBRA. Further, if a **Bargaining Employee** becomes **Disabled** during a period of Continuation Coverage under COBRA then each month of Disability Credit will count as one month of COBRA coverage. In no event will a **Disabled Employee's** coverage be continued, by virtue of Disability Credits, past the maximum period of coverage permitted in accordance with the Rules for Continuation Coverage Following Termination under COBRA.

ARTICLE IX. ARMED FORCES

Coverage in the **Plan** shall be terminated for an **Employee**, and his **Covered Spouse,** and/or his **Covered Dependents**, if applicable, on the date the **Employee** voluntarily enlists or is called to full-time active duty in the **Armed Forces** of the United States of America, while any hours remaining in his Reserve Account shall be frozen during the period of such active duty. However, as noted below, if the **Employee** does not notify the **Plan** prior to actual entry into active duty then all hours existing in their Reserve Account as of the date their active duty commences will continue to be applied toward maintaining continuous coverage for themself and their **Covered Spouse/Child(ren)**, if applicable, and may not be frozen to be applied to subsequent coverage upon their being discharged. Coverage for **Employees** who provided the **Plan** with timely notice of the commencement of their active duty, and their **Covered Dependents**, who are discharged from the **Armed Forces** will be reinstated, along with any remaining frozen Reserve Account hours, on the date they are re-employed by a **Contributing Employer**, if they secure such re-employment within 90 days after their discharge from the **Armed Forces** or within 90 days after their discharge from a **Hospital** if they are hospitalized at the time of their discharge from the **Armed Forces**, or make proper application for employment on the **Union's** "out of work" book. It is the responsibility of any such **Employee** to advise the Trust Office immediately of their entrance into the **Armed Forces** prior to actual entry and, similarly, immediately upon their discharge. Failure to do so shall terminate all eligibility for benefits, while also resulting in the forfeiture of all Reserve Account hours and eligibility to remit **Direct Payments** upon induction into the **Armed Forces**. Any claim for benefits made by an **Employee** who re-establishes his eligibility under this Article shall be subject to the Coordination of Benefits provision of this **Plan**. However, the **Covered Employee** and/or any **Covered Dependent** may elect to continue their coverage for up to 24 months in accordance with USERRA. If you do not elect USERRA coverage, your **Covered Dependents** can elect COBRA coverage. USERRA and COBRA coverage shall run concurrently.

ARTICLE X. DEPENDENTS OF DECEASED EMPLOYEES

Benefits for **Covered Dependents** of a deceased **Covered Employee** will continue for the period of time during which the **Employee** would have been eligible had he not died. Such coverage shall include utilization of all Reserve Account hours which the deceased **Employee** had accumulated. There will be no provision for continuation of coverage beyond that date under the **Plan**, except as provided under Continuation Coverage Following Termination Under COBRA.

ANNUAL ENROLLMENT

Each October all **Covered Employees** in **Plan A** will receive communication from the Trust Office outlining the monthly costs of coverage for the following calendar year and will have an opportunity to change medical coverage for themself and their **Dependents** (HMO to PPO or PPO to HMO)**.** This change will become effective on the following January 1st and will remain in force for the entire calender year, even if the **Covered Employee's** coverage is terminated and subsequently reinstated as provided for in the eligibility rules for **Plan A**.

IBEW RECIPROCAL PROGRAM

The Health & Welfare **Trust** is signatory to the Electrical Industry Health & Welfare Reciprocal Agreement. This is a "money follows the man" program providing for **Employee**s working outside of the jurisdiction of IBEW Local 569 to elect to transfer their hours and corresponding contributions back to their designated "Home Fund" for the purpose of maintaining continuous coverage in that **Plan**.

An **Employee** may designate any IBEW Local Union's Health & Welfare **Plan** as their "Home Fund" if they have been a covered participant at any time within the immediately preceding 6 year period. It is required that the designated "Home Fund" agree to accept an **Employee**'s contributions prior to the commencement of transferring their hours.

This program provides for the transfer of the lessor of the then current Health & Welfare contribution rate in the Local 569 Inside Agreement or in the Local Union where the work is performed. In the event the contribution rate transferred back to this **Trust** is less than the current contribution rate in the Inside Agreement the corresponding hours will be pro-rated to an equivalent number of hours which, if reported at the full contribution rate, would generate the same total of contributions received. As an example, if the current Local 569 contribution rate is $6.63/hr and 100 hours from another plan is received at a rate of $4.00, the 100 hours would be reduced by 40% ($4.00/$6.63) and the **Employee** will be credited with 60 hours for the month for which the hours are being reported.

In order to register to participate in the Electrical Reciprocal Transfer System (ERTS), an electronic online system intended to permit traveling **Employee**s to monitor the reporting of their hours, each **Employee** must appear at their home or visiting local and register each time they wish to have their hours transferred to another plan as the receiving plan must approve acceptance of their hours and contributions. This process must also be followed to stop transferring hours or to designate a different "Home Fund" to transfer their hours to.

ELIGIBILITY FOR NON-BARGAINING EMPLOYEES UNDER PLAN A

ARTICLE I. COVERED EMPLOYEES

In order to be eligible for benefits under **Plan A**, a **Non-Bargaining Employee** must be specifically named or otherwise provided for in a Participation Agreement signed by a **Contributing Employer** and approved by the **Trustees**.

Enrollment of any **Non-Bargaining Employee** must be made to the Trust Office by no later than the first day of the month following the date the **Contributing Employer** signs a Collective Bargaining Agreement with the **Union** or the first day of the month following the **Non-Bargaining Employee's** initial date of employment. Failure to do so will result in the requirement that the **Non-Bargaining Employee**, and each of his **Dependents**, be subject to the late enrollment rules under the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**).

In order for an **Employer** to be eligible to contribute on any **Non-Bargaining Employee(s)** an office or site location for operating in the electrical construction business must be located within the geographic jurisdiction of IBEW Local 569 or in an adjoining jurisdiction. Further, to be eligible to participate under these Eligibility Rules a **Non-Bargaining Employee**'s primary residence must be within this same geographic area and they must work primarily in or through said business location.

Participation in **Plan** B Kaiser will be permitted for only **Non-Bargaining Employees** who have never previously participated in **Plan A**. However, with respect to participation in **Plan A** or **Plan B** Kaiser, the **Non-Bargaining Employee** must satisfy Kaiser's then current requirement with respect to their residence or primary work location being within a Kaiser service area falling within the preceding paragraph outlining the geographic area for participation under these Eligibility Rules.

The payment of contributions by a **Contributing Employer** on behalf of particular **Non-Bargaining Employees** does not make any such **Employee**, or his eligible **Dependents**, eligible for benefits unless a written Participation Agreement is signed by the **Contributing Employer**, approved by the **Trustees**, and the **Contributing Employer** assumes all liability under **ERISA** with regard to such **Non-Bargaining Employee(s)** and their eligible **Dependents**.

The following criteria shall apply to any newly signatory employer who becomes signatory with the **Union** that does not employ at least one **Bargaining Employee** as of the date of execution of their collective bargaining agreement:

(a) If the principal(s) of the newly signatory **Employer** was/were not a **Covered Bargaining Employee** as of the date they became a signatory **Employer,** the remittance of hours toward establishing their coverage under the Plan may not commence until the **Employer** has hired a **Bargaining Employee** for at least 3 months. Continued participation will be contingent upon the hiring of at least one **Bargaining Employee** for a minimum of 3 calendar months each calendar year.

(b) If the principal(s) of the newly signatory **Employer** was/were eligible in Plan A at the time they became a signatory **Employer** there will be no minimum hiring requirement and contributions may be remitted in the required manner to maintain continuous coverage under these Eligibility Rules.

ARTICLE II. CONTRIBUTIONS

Contributions due on behalf of **Non-Bargaining Employees** must be made on a timely basis to continue coverage under this **Plan**. The term "timely basis" is defined in Article VII., A. of the Rules For Continuation Coverage Under COBRA . The **Employer** is required to remit the necessary hours to cover each **Non-Bargaining Employee's** full cost of coverage, recognizing **Direct Payments** are not permitted to maintain coverage.

ARTICLE III. ELIGIBILITY

Coverage will become effective for the **Non-Bargaining Employee**, and their **Covered Dependents**, as of the first day of the second month following the **Employers'** remittance of the required amount of hours and contributions for 2 consecutive months, subject to the same **Pre-existing Condition** provisions applicable to **Bargaining Employees** and their **Covered Dependents**. Each **Non-Bargaining Employee** shall also be subject to the same "**Armed Forces**" requirement applicable to **Bargaining Employees**.

It will be possible for coverage of a **Non-Bargaining Employee** to be maintained during an absence from full-time employment while on an authorized leave absence, not to exceed 3 months, temporary lay-off or temporary part-time employment provided a written application is submitted in advance of the termination of the **Non-Bargaining Employee's** coverage and is approved by the **Trustees**. Upon approval of said application, the **Contributing Employer** will be required to continue to remit the required hours and contributions on a timely basis.

Coverage for **Covered Dependents** of a deceased **Non-Bargaining Employee** will continue for the period of time during which the **Non-Bargaining Employee** would have been covered had he not died. **Covered Dependents** are not eligible for continuation of coverage beyond that date, except as provided under Continuation Coverage Following Termination under COBRA.

Newly Organized Employees - Non-Bargaining Employees of newly organized/enrolled or existing Contributing Employers subject to this provision shall also be entitled to immediate coverage under this Plan provided all of the requirements set forth in Part A of the amended portion of Article III. above are satisfied. Coverage for **Non-Bargaining Employees** shall become effective concurrent with the effective date of coverage for **Bargaining Employees**.

The **Plan** provisions entitled "Eligibility for **Non-Bargaining Employees** under Plan A" do not provide for the accrual of Reserve Account hours. However, any **Non-Bargaining Employee** receiving immediate coverage under this Amendment will have remitted on their behalf by their **Employer** an additional 10 hours per month commencing with their first month of participation as a means of recovering the hours advanced for their period of immediate coverage equal to three months of the then current **Non-Bargaining Employee** cost of coverage for Trust Medical Benefits. Under no circumstances will any newly organized **Non-Bargaining Employee** be granted more than one opportunity for immediate coverage under these Eligibility Rules.

ARTICLE IV. RESERVE ACCOUNT

Non-Bargaining Employees are not entitled to the accrual of Reserve Account hours. However, any Reserve Account hours accrued as a **Non-Bargaining Employee** prior to 2/1/94 may be utilized as previously provided for in this Article. In the event a **Non-Bargaining Employee's** remaining Reserve Account hours are not sufficient to maintain coverage no **Direct Payments** will be allowed for the purpose of continuing such coverage and all such remaining Reserve Account hours will revert to the general reserve of the **Trust**.

If the **Non-Bargaining Employee** had accrued Reserve Account hours as a **Bargaining Employee,** all such Reserve Account hours will be frozen upon the **Contributing Employer** remitting the first month of contributions on the **Non-Bargaining Employee's** behalf and may only be reinstated if the **Non-Bargaining Employee** again becomes a **Bargaining Employee** or converted to a **Plan C** Reserve in conjunction with their qualification for, and effectuation of, **Plan C** coverage.

ARTICLE V. TERMINATION

Eligibility for **Non-Bargaining Employees**, and their eligible **Dependents**, shall be terminated immediately, and without the need for notice, if his **Contributing Employer** fails to timely make payment of all hours and contributions due on behalf of its **Bargaining** and **Non-Bargaining Employees** or if his **Contributing Employer** is no longer signatory to a **Union** Agreement. All coverage shall be terminated as of the first day of the month following the month for which contributions were not paid in full or for which the **Contributing Employer** was not signatory.

In the event coverage terminates for any **Non-Bargaining Employee**, and/or his **Covered Dependents**, the only means by which coverage may be maintained will be in accordance with the Rules of Eligibility for Continuation Coverage Following Termination Under COBRA.

RULES FOR CONTINUATION COVERAGE FOLLOWING TERMINATION UNDER COBRA FOR PLAN A AND PLAN B

ARTICLE I: ELIGIBILITY FOR CONTINUATION COVERAGE

A. Covered Employee--A **Covered Employee** shall be eligible to elect Continuation Coverage if his coverage is terminated due to a **Loss of Coverage** (except if the loss of coverage occurred if the **Covered Employee** continues in the employ of his **Employer** and his **Employer** is no longer signatory to a **Collective Bargaining Agreement** with the **Union**).

B. Dependents--A **Covered Dependent** shall be eligible to elect Continuation Coverage on their own behalf even if the **Covered Employee** fails to elect Continuation Coverage if his coverage is terminated due to a Qualifying Event. A "Qualifying Event" includes only the following events:

(1) The **Covered Employee** suffers a **Loss of Coverage** (except if the **Covered Employee** continues in the employ of his **Employer** and his **Employer** is no longer signatory to a Collective Bargaining Agreement or his **Employer** fails to make timely contributions due to this **Plan**);

(2) The death of the **Covered Employee** or Retiree; or

(3) The **Covered Employee** or **Retiree** becomes entitled to Medicare benefits as defined in Article VIII, (3) of this set of Rules; or

(4) The termination of marriage between the **Covered Employee** and **Covered Spouse** by Judgement of Dissolution or Annulment; or

(5) The termination of a domestic partnership between the **Covered Employee** or **Retiree** and the **Domestic Partner**; or

(6) A **Covered Child** ceases to be eligible for coverage as a **Dependent Child**.

C. Ineligible Persons--A **Covered Person** whose coverage is terminated for any other reason than those listed above shall not be eligible to elect Continuation Coverage. A **Dependent**, other than a newborn **Child** or a **Child** placed for adoption with a **Covered Employee** who was not a **Covered Dependent** as of the day before the **Covered Employee's** initial **Loss of Coverage** (except if the **Covered Employee** continues in the employ of his **Employer** and his **Employer** is no longer signatory to a Collective Bargaining Agreement or his **Employer** fails to make timely contributions due to this **Plan)** shall also not be eligible to elect Continuation Coverage.

The terms "placement, or being placed for adoption" in the above paragraph and in Article VI, (D) of this set of Rules means the assumption and retention by the **Covered Employee** of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. If such an obligation terminates, so does the placement for adoption.

ARTICLE II. ELECTION OF CONTINUATION COVERAGE

A. Written Election--A person who is eligible to elect Continuation Coverage must sign a written Election Form approved by the **Trustees**. The person may elect to receive either full benefits or core benefits only as defined in Article III. of this Section.

B. Time for Election--A written Election Form must be sent to the Trust Office no later than 60 days after the person's date of loss of coverage, or if later, 60 days after the date the person was notified of their loss of coverage. However, in order to make a separate election of coverage by a **Covered Spouse,** Domestic Partner, or Covered Child, or to extend coverage due to disability, death of the Covered Employee, divorce or loss of Covered Dependent status, the Trust Office must first have received timely notice of such disability, death, divorce or change in dependent status. The required notices and their due dates are described in Article VII. (Notice of Important Events).

C. Persons Covered--Continuation Coverage may be elected for **Covered Employee**s and their **Covered Dependents**. However, Continuation Coverage shall not be extended to a divorced **Spouse** or terminated **Domestic Partner** or **Dependent Child** unless a separate election is made, and unless they are eligible at that time to make an election on their own behalf in accordance with Article VII., D. of these Rules.

ARTICLE III. BENEFITS PROVIDED

Any eligible person who timely elects and timely pays the premium for Continuation Coverage shall have the right to receive either of the following benefit packages as elected by the eligible person:

A. Full Benefits-The same medical, dental and vision benefits as are provided to all **Covered Employees** under **Plan A**, but excluding any basic or supplemental life insurance coverage; or

B. Core Benefits-The same medical benefits as are provided to all **Covered Employee**s under **Plan A**, not including dental benefits and vision benefits, (if applicable), and not including any basic or supplemental life insurance coverage.

C. Change of Benefits-The benefits provided for all **Covered Persons** may be changed or eliminated at any time by the **Trustees**. Benefits paid will always be in accordance with the Schedule of Benefits in effect at the time services are rendered.

ARTICLE IV. COST OF COVERAGE

A. Premium Amount--A person eligible to elect Continuation Coverage shall pay the current cost of coverage as provided herein plus 2% administrative fee. The cost of coverage shall be determined by the **Trustees**, which shall be reviewed, and may be adjusted, from time to time. The current cost of coverage may vary if the **Plan** provides dental or vision benefits, or if Continuation Coverage is extended due to a disability. The cost of coverage for all **Covered Persons**, during any extension period due to disability will be at 150% of the current Continuation Coverage cost of coverage plus 2% administrative fee.

B. Monthly Installments--The cost for Continuation Coverage may be paid in monthly installments in the following manner:

(1) Upon making the initial written election on a timely basis the eligible person, if a **Bargaining Employee** who was covered under **Plan A** for the month preceding the effectuation of Continuation Coverage, coverage for the first 12 consecutive months of Continuation Coverage will be charged at the then current contribution rate for **Plan A** coverage multiplied by the number of hours required to maintain coverage. The remaining 6 consecutive months (17 months if **Totally Disabled**) of Continuation Coverage would be charged at the then

current COBRA premium rates and will require a new written election as to Benefits Provided only under Article III. of these Rules. In the event such an election is not received by the first day of the 13th month of Continuation Coverage the **Plan** reserves the right to presume the **Bargaining Employee** elected to maintain the same coverages in effect as of the 12th month of Continuation Coverage and to impose the then current premium for said coverages.

(2) For all other eligible persons the then current COBRA premium will be charged for their entire period of Continuation Coverage.

ARTICLE V. DUE DATES FOR PAYMENT

A. Timely Payment Required--Except for the first payment of Continuation Coverage, each premium payment is due at the Trust Office by the first day of the month for which coverage is to be provided.

B. First Payment--The payment for the first month(s) of Continuation Coverage must be received by the Trust Office no later than 45 days after the date the Trust Office receives the completed Election Form. All payments due for the first month or more of Continuation Coverage must also be paid with the first payment.

C. Grace Period--The **Plan** provides a 30 day grace period following the due date. This grace period does not apply to the first payment but only to monthly payments due thereafter. Any payments received by the Trust Office after the grace period ends will not be timely and will result in termination of Continuation Coverage as of the last day of the month for which the premium was paid on a timely basis. If Continuation Coverage ends, coverage cannot be reinstated, and re-qualification is permitted only in accordance with the Rules of Eligibility for **Plan A** participants.

D. Summary of Dates for Monthly Installment Payments:

Month of Coverage	**Installment Due Date**	**Grace Period Ends**
January	January 1	January 31
February	February 1	March 3
March	March 1	March 31
April	April 1	May 1
May	May 1	May 31
June	June 1	July 1
July	July 1	July 31
August	August 1	August 31
September	September 1	October 1
October	October 1	October 31
November	November 1	December 1
December	December 1	December 31

ARTICLE VI. LENGTH OF CONTINUATION COVERAGE

A. 18 Month Coverage--Any **Covered Person** whose coverage is terminated due to a loss of coverage of the **Covered Employee** may be eligible to elect Continuation Coverage for up to 18 months from the date of their loss of coverage, provided they do not become covered by another group health plan after the date of their election of Continuation Coverage, provided the new coverage does not contain any exclusion or limitation with respect to any **Pre-existing Condition** of such person.

B. 36 Month Coverage--Any **Covered Person** whose coverage is terminated for any qualifying event other than the loss of coverage of the **Covered Employee's** may be eligible to elect Continuation Coverage for up to 36 months from the date of his original loss of coverage. If the **Covered Person** is covered under **Plan A** Kaiser they are entitled to elect Continuation Coverage under CAL-COBRA for up to 36 months from the date of his original loss of coverage, even if the qualifying event is due to a loss of coverage as a result of termination of employment or reduction in hours.

C. 11 Month Extended Coverage Due to Disability--If a **Covered Employee** or **Covered Dependent**, as applicable, is **Totally Disabled** at the time of their initial Qualifying Event or becomes **Totally Disabled** within the first 18 months of Continuation Coverage, or has an application for Social Security Disability benefits pending as of the expiration of the first 18 months of Continuation Coverage, each person eligible for Continuation Coverage may elect to have their original 18 months of Continuation Coverage extended for up to 11 months. In order to qualify for the 11 month extension of coverage, the **Covered Person** must have been determined to be **Totally Disabled** according to the requirements of the Social Security Administration by no later than the end of their 18th month of Continuation Coverage and have provided the **Plan** Administrator with a copy of the Social Security determination

within 60 days of the date of the determination. However, if a **Covered Employee** had exhausted the maximum of twelve (12) months of Disability Credit prior to the commencement of their Continuation Coverage, and they have filed for a disability determination through the Social Security Administration which has not yet been adjudicated as of the eighteenth (18^{th}) month, they may elect to extend their original period of Continuation Coverage for up to eleven (11) months, to include Continuation Coverage for their eligible dependents in accordance with the Rules for Continuation Coverage.

D. Extending Coverage Due to Multiple Qualifying Events--If a subsequent Qualifying Event occurs after coverage is terminated due to the **Covered Employee's** initial Qualifying Event, then the **Covered Dependent** previously covered by Continuation Coverage may be eligible to elect Continuation Coverage on their own behalf, but not to exceed 36 months from the initial date of eligibility for Continuation Coverage. However, no such election due to multiple qualifying events shall be permitted for any person, other than a newborn **Child** or a **Child** placed for adoption with a **Covered Employee**, who was not a **Covered Person** immediately before the **Covered Employee's** Continuation Coverage first began and Coverage shall terminate at the end of the initial period of Continuation Coverage.

ARTICLE VII. NOTICE OF IMPORTANT EVENTS

A. Monthly Reports Due From Employers--The **Contributing Employer** of the **Covered Employee** must report to the Trust Office within 15 days after the end of the month the number of hours worked by each **Bargaining Employee**, as well as remit the required contributions due thereon and for all participating **Non-Bargaining Employees**. The **Contributing Employer** shall also notify the Trust Office when any of the following events occur if the **Employee** was still in the employ of the **Contributing Employer** during that month:

(1) the termination of employment or reduction of hours of the **Covered Employee**; or

(2) the death of the **Covered Employee**; or

(3) the **Covered Employee** becomes covered by Medicare benefits.

This requirement may be met by timely filing a required monthly reporting form containing this information with the Trust Office.

B. Notice of Disability Status From Employee, Spouse and Children--The **disabled** person **(Covered Employee** or **Covered Dependent)** must notify the Trust Office in writing of their disability status within 60 days after the date their **Total Disability** determination is issued by the Social Security Administration and before the end of the original 18-month Continuation Coverage period. The **Totally Disabled** person must also notify the Trust Office in writing of their no longer being disabled no later than 30 days after the date the final determination is issued by the Social Security Administration.

C. Financial Responsibility for Failure to Give Notice--If a **Covered Employee** or **Covered Dependent** fails to give proper notice of their age or any change of address, marital, dependent, or Medicare eligibility or **Total Disability** status and, as a result, the **Plan** pays a claim or premium for a person who should have been terminated, the **Plan** shall have the Right of Recovery of all improperly paid benefits or premiums.

D. Loss of Coverage for Failure to Give Timely Notice--If a **Covered Employee** or **Covered Dependent** fails to give notice to the Trust Office ***within 60 days*** of their age or any change of address, marital, **Dependent**, **Disability** status or Medicare eligibility the person will lose their right to elect extended Continuation Coverage or separate coverage.

ARTICLE VIII. TERMINATION OF COVERAGE

A. Termination--Continuation Coverage shall be terminated on the earliest of the following events:

(1) non-payment of premium in full by the end of the grace period; or

(2) the person becomes covered under any other group health plan (as an employee or otherwise) after the date of their election of Continuation Coverage, provided the new coverage does not contain any exclusion or limitation with respect to any **pre-existing condition** of such person; or

(3) the person becomes entitled to Medicare benefits. For the purpose of this provision a person will be considered "entitled to Medicare" if they attain age 65 and are eligible for Medicare if the person has applied for Social Security benefits or has filed an application for Medicare Part A; or

(4) for dependents only--the **Spouse** or **Child** ceases to be a "**Covered Dependent**" and do not timely elect their own Continuation Coverage. Also, upon the death, termination of domestic partnership or divorce of the **Covered Employee** after the initial qualifying event, other than a newborn **Child** or a **Child** placed for adoption with a **Covered Employee**, Continuation Coverage shall immediately terminate for a **Covered Dependent** who was not a **Covered Person** before Continuation Coverage first began; or

(5) for disabled persons only--the person is no longer **Totally Disabled** as finally determined by the Social Security Administration; or

(6) the **Trust** stops providing any group health benefits to all **Covered Persons**.

B. Date of Termination--Continuation Coverage shall immediately stop, without notice, on the first date of the month that begins more than 30 days after any of the above described events. In such event, the person must still pay the full premium for Continuation Coverage until the coverage stops.

C. No Right of Requalification--There is no right of requalification of eligibility under this **Plan** after termination, except upon re-qualification in accordance with the Rules of Eligibility for **Plan A** participants.

ARTICLE IX. NO CONVERSION OPTION

A conversion option shall be available to any person covered under Continuation Coverage only if such right of conversion to an individual enrollment is otherwise available to all other **Plan A** participants. There is no conversion option available to any **Covered Persons** at this time except for life insurance (basic and supplemental benefits) and/or a prepaid medical/dental Plan to the extent permitted by the **Provider(s)**.

ARTICLE X. ARMED FORCES

A. In the event a **Participant** is on military leave-of-absence from his or her regular employment, and the period of military service exceeds 31 days, the **Participant** and his or her **Dependents** will be eligible for continuation coverage under the USERRA, for a period not to exceed 24 months, beginning on the date on which the **Participant's** absence for military leave begins. The cost of coverage under this provision shall be determined in accordance with this **Plan's** prevailing COBRA premiums. USERRA and COBRA continuation coverages shall run concurrently.

(1) A **Participant** may utilize his or her Reserve Account hours to maintain continued coverage under this **Plan** before paying for such coverage in accordance with the prevailing COBRA premiums. Upon exhaustion of the **Participant's** Reserve Account hours, the **Participant** shall be entitled to obtain continuation coverage by paying the applicable COBRA premium for the remainder of the 24 month period.

B. In the event a **Participant** is on military leave-of-absence from his or her regular employment and the period of military leave does not exceed 31 days, the **Participant** and his or her **Dependents** will continue to be eligible for coverage under this **Plan** provided that the **Participant** pays the **Plan** the applicable amount of the **Participant's** portion of any premium for the month in which the **Participant** is on military leave-of-absence.

C. The **Participant** shall be required to notify the Trust Office of his or her need for continuation coverage while on military leave and furnish the **Plan** with the copy of the **Participant's** military orders for the period in which continuation coverage is requested.

D. Under no circumstances will the **Plan** be liable for any claims incurred by the **Participant**, or their **Dependent(s)**, for treatment received from the federal government for any service-related injuries or illnesses.

E. In the event the **Participant's** coverage under this **Plan** terminates for any reason during the **Participant's** military leave-of-absence, no exclusion or waiting period will be imposed on the **Participant** or his or her eligible **Dependent(s)** upon return to employment. However, the pre-existing condition provisions of this **Plan** shall apply with respect to any service-related illnesses and injuries, as well as those pre-existing condition exclusions that would otherwise apply had there been no military leave.

F. Nothing in this Section shall require the **Plan** to provide any greater coverage or benefits not otherwise provided under the terms of this **Plan.**

COVERAGE AFTER TERMINATION FROM TRUST MEDICAL PLAN

If a **Covered Person** becomes **Disabled** while the **Covered Person** is eligible for coverage, benefits will be paid for any **Eligible Expenses** incurred after the date of **Loss of Coverage** resulting from and relating to such **Disability** and only during the uninterrupted continuance of said **Disability**, but not to exceed a period of up to 12 continuous months from the date of **Loss of Coverage**. Benefits payable after the **Plan Year** in which coverage was terminated are subject to a new deductible.

Benefits payable under this provision shall cease on the earliest of:

1) Twelve continuous months from the **Covered Person's** date of loss of coverage;

2) The date the **Covered Person** is no longer **Disabled**; or

3) The date the **Covered Person** becomes eligible for coverage under a Group Insurance Program, unless the **Covered Person** is eligible, and makes a timely election, for Continuation Coverage Following Termination Under COBRA.

PLAN A SERVICE PROVIDERS

PREFERRED PROVIDER ORGANIZATIONS (PPO)

Blue Cross of Southern California -- the **Trust** participates in the Blue Cross Preferred Provider Organization (PPO) which has contracted with many local ***and national*** **Physicians** and major **Hospitals** to provide medical care at rates below their normal rates. When a **Covered Person** requires hospitalization or **out-patient** services and chooses one of the PPO

Hospitals, he will not have to pay the hospital deductible as stated in the Schedule of Benefits, as well as enjoying the substantial savings from the **Hospital's** contractual arrangement with the PPO to discount its charges. When a **Covered Person** chooses a PPO **Provider**, the **Provider** will accept this **Plan's Allowable Charge** as "payment in full", subject to the **Plan** and the Schedule of Benefits as to deductibles, co-payments, limitations and exclusions.

Sharp Rees-Stealy -- Sharp Rees-Stealy is recognized as a PPO **Provider** for all services other than the routine physical exam program, which is operated pursuant to an exclusive contract arrangement through its Occupational Medicine Facility.

SIMNSA Network– As of January 1, 2008 participating providers in the SIMNSA Network within specified portions of Mexico will be recognized as **PPO Providers** under **Plan A**. The location of available providers will be determined by SIMNSA and may change at any time.

Hospital Pre-admission and Admission Review -- Blue Cross also provides **Hospital** pre-admission and admission review program. When a **Covered Person** is scheduled for admission into any **Hospital**, whether a PPO **Hospital** or not, or whether in or out of San Diego County, he is required to direct the admitting **Physician** to notify Blue Cross, who will pre-certify the admission or discuss an alternate basis of treatment with the **Physician**. Failure to notify Blue Cross of a scheduled **Hospital** admission may result in the denial of benefits for services not considered to be **Medically Necessary** by Blue Cross' retrospective review program.

Case Management -- This **Plan** also utilizes Blue Cross to provide concurrent review of **Hospital** admissions, retrospective review of **Hospital** admissions and medical treatment, peer review of disputed claims for **Hospital** charges and Case Management. Case Management is a program pertaining to catastrophic disabilities and chronic disease processes requiring long term usage of health care **Providers**. The **Plan** requires that all **Covered Persons** agree to, and cooperate with, the assignment of a Blue Cross case manager acting on behalf of both the patient and the **Plan.** As with PPO **Providers**, use of these services is intended to reduce the cost of claims in the spirit of cost containment.

PACIFIC FOUNDATION FOR MEDICAL CARE

This **Plan** utilizes the Pacific Foundation for Medical Care to provide pre-certification of out-patient services, review claims to determine medical necessity and for peer review of disputed claims involving **Physician's** and/or **Hospital** charges and services. Use of these services is intended to reduce the cost of claims in the spirit of cost containment, while at the same time making quality medical care available to all **Covered Persons**. However, the **Plan** reserves the right to utilize any other entity instead of or in addition to the Pacific Foundation for Medical Care for the purpose of providing the aforementioned services.

INDEPENDENT MEDICAL REVIEWS

The **Board of Trustees** shall have the discretion to obtain one or more independent medical reviews from independent service providers to provide pre-certification of out-patient services, review claims to determine medical necessity and for peer review of disputed claims involving **Physician's** and/or Hospital charges and services. Use of these services is intended to reduce the cost of claims in the spirit of cost containment, while at the same time making quality medical care available to all **Covered Persons**.

In the event multiple independent medical reviews, as outlined above, are requested by the **Plan**, and the results of said reviews utilizing comparable criteria provide varying results or recommendations as to whether a service is medically necessary and/or what the **usual & customary** maximum allowable charge(s) would be for a covered service, the **Board of Trustees** reserves the right to accept or reject, in whole or in part, any or all such reviews when deciding whether to approve a claim for payment or how much of the billed charges will be deemed eligible for payment. Should there be three or more independent medical reviews, with two or more providing reasonably similar results, the **Board of Trustees** may recognize those results or any combination thereof and ignore the remaining review in whole or in part when making a final decision.

CVS/CAREMARK

CVS/Caremark is the **Plan's** Pharmacy Benefit Manager providing an array of services incorporating discount pricing for prescription medications and aggressive cost containment programs focusing on reducing overall drug spending as well as the health of the **Covered Person**.

The following is a brief description of the cost-containment programs currently in place:

Mandatory Mail Order: After initially filling a new prescription of a maintenance medication (i.e. one to be taken regularly for a sustained period of time) all subsequent refills must need be acquired through one of CVS/Caremark's mail facilities. The lowest medication pricing and reduced fees make this the most economical means for re-filling maintenance medications which are issued in 90 day quantities versus a maximum of 30 days for locally filled prescriptions.

FastStart: Participants may initiate their mail order prescriptions simply by calling a toll free number and speaking with a CVS/Caremark Pharmacist and Pharmacy Technician. CVS/Caremark will contact their Doctor to confirm the prescription(s) and get the patient started with mail order. There is also a toll-free number that a Doctor can use to call-in prescriptions.

Mandatory Generic: Whenever a generic alternative to a prescribed medication is available it will be utilized to fill a prescription. If a brand name medication is mandated by the participant then they will be required to pay the full cost differential between the brand and generic versus only 20% of the much lower generic cost

Generic Uptake Program: Promotes the use of new generic drugs to market. Pharmacists are alerted as to the availability of new generic drugs and provides additional cost savings to both the participant and the Plan.

Performance Rx - The pharmacists support Plan participants by working with them and their physician to develop the lowest net cost strategy by utilizing the most cost-effective medication(s) for the diagnosis.

Custom Care Retail - This program focuses first on the participant's health and safety in an effort to improve outcomes and provide savings by identifying participants who may be at risk for drug interactions or drug-induced disease conditions by using retrospective claims analysis and system-driven edits. This program also identifies appropriate opportunities to simplify therapies and minimize unnecessary prescriptions by reviewing specific product selection, dosage, quantity & duration.

Additional cost-containment programs may be added or some existing programs may be modified or removed by the Board of Trustees at any time.

ALERE (formerly ACCORDANT)

Disease Management – This program was implemented for the purpose of assisting participants afflicted by chronic disease(s) with improving their overall health, and at the same time preventing or reducing costly related treatment(s) and medication(s).

BEST DOCTORS

Recognizing the importance of making sure that any and all serious diagnoses, recommended surgeries or medications are correct before undergoing surgery, starting a plan of treatment or extensive medication regimen, Plan A PPO participants may seek independent confirmation of a diagnosis and/or treatment plan through "Best Doctors" which will perform a confidential Best Doctors Check-up at **no cost to you**.

The main reasons people contact Best Doctors are: No diagnosis, not understanding a diagnosis, symptoms not improving, questions as to the need for recommended surgery, or a need for help in deciding between multiple proposed treatment options.

By calling Best Doctors (1-866-904-0910) a Member Advocate will listen to and answer all questions as to a diagnosis and a proposed treatment plan. The Member Advocate will take the participant's complete medical history and if further review is warranted Best Doctors will aggregate all medical information including all physician records and tests. Following a very extensive and detailed review by expert physicians, Best Doctors will deliver to the participant and their physician a summary of their findings as to whether the diagnosis and/or plan of treatment is on target. If necessary, Best Doctors will match participants with an expert PPO physician.

There have been questions as to whether using Best Doctors will require replacing your relationship with your current physician(s). The answer is "no" as this program is intended to offer additional resources, education and support to both the participant and their treating physician. Statistics show that well over 90% of the time the participant's treating physician works in tandem with Best Doctors in the patient's best interests to focus on "getting it right".

In any situation where you may be dealing with a significant medical condition, recommended surgery or extensive treatment plan we urge you to find out more about the Best Doctors program or services by calling 1-866-904-0910, going to www.bestdoctors.com or to send your diagnosis or treatment plan through to Best Doctors you should email info@bestdoctors.com.

Please keep in mind that a participant must be eligible for Plan A PPO coverage at the time the Best Doctors service is sought as well as when any resulting medical services are rendered in order for such services or group medical coverage to be applicable.

Should there be any questions as to when and how to use the Best Doctors program please contact the Trust Office.(858-569-6322, x-702).

SATORI WORLD MEDICAL

To assist Plan A PPO participants dealing with a complicated or extreme surgical procedure/medical plan of treatment a network of leading facilities throughout the United States, which have become recognized as true "Centers of Excellence", is being made available though Satori World Medical **at no cost** to the participant. However, any medical services rendered by service providers procured through the Satori World Medical network will be payable in accordance with the provisions of the **Plan** and the PPO Schedule of Benefits.

Use of one of these Centers of Excellence, which specialize in cardiac procedures, cancer treatment, and transplant programs, is totally voluntary. From beginning to end, this program affords ongoing support to the patient and their family. Included in this service Satori will make all arrangements for use of the participant's chosen medical facility to include, if necessary,

coordination between a local physician and the selected facility/providers as well as making travel and lodging arrangements for the patient and any companion family or a friend. One last advantage of pursuing the Satori Center of Excellence program is that their service provider rates should be no more, and expectedly less, than PPO pricing for the very same providers.

The two main advantages of looking into using a Satori World Medical identified "Center of Excellence" are:

1. Immediate identification as to which facilities in the U.S. are recognized as providing the highest quality of service or treatment for the participant's diagnosis or plan of treatment; and
2. The participant (and their family) will receive "hands-on" assistance commencing with determining which "Center of Excellence" would be expected to provide the best possible outcome. Once that has been determined there will be assistance and oversight services including preparatory planning and scheduling, making travel arrangements and coordination between local physicians and the selected specialist(s) and facility.

To find out more about the Satori World Medical program go to www.satoriworldmedical.com. To speak to a nurse advocate call (619) 704-2000 in San Diego County or (866) 613-9686 toll free.

PLAN B

SCHEDULES OF BENEFITS FOR PLAN B KAISER (HMO)

The basic premise of an HMO plan is that the **Covered Person** receives most services at no out-of-pocket expense so long as recognized **Hospitals** and **Providers** are utilized. However, in some instances there are co-payments required to be paid on a fee for service basis. The following is a brief description of the current Schedule of Benefits, while all pertinent information is contained in the brochure "*Your Health Plan Coverage"* published by Kaiser Permanente, available at the Trust Office.

EMPLOYEE AND DEPENDENTS (NON-MEDICARE):

Type of Service	Co-payment
Hospital	
• Room & Board, surgery, anesthesia, X-rays, lab tests and drugs	$500 Per Admission
Physician	
• Office Visits (routine and Urgent Care), physicals, vision and hearing exams, well child care (over 23 months of age), physical, occupational and speech therapy visits, allergy testing, Health Education & Family Planning	$30 per visit
Outpatient Surgery	$30 per procedure
Laboratory, x-ray, diagnostic tests	No Charge
Ambulance - Within service area	$50 per trip
Home Health Care (up to 100 two-hour visits per calendar year)	No Charge
Hospice Care	No Charge
Skilled Nursing Care	
• Up to 100 days per benefit period	No Charge

Type of Service	Co-payment
Prescriptions	
• Covered Prescriptions - Generic	$10 per prescription (Up to 100-day supply or 3 cycles for oral contraceptives)
• Covered Prescription - Brand Name	$25 per prescription (Up to 100-day supply or 3 cycles for oral contraceptives)
Alcoholism/Substance Abuse	
• Inpatient Detoxification	$500 per admission
• Transitional residential recovery services (60 days per calendar year not more than 120 days in a 5-year period)	$100 per admission
• Outpatient Individual Therapy	$30 per visit
• Outpatient Group Therapy visits Mental Health Care	$ 5 per visit
• Up to 30 days of in-patient **hospital** care	$500 per admission
• For the first 20 out-patient visits per calendar year (individual or group)	$30 per individual therapy visit
• Up to 20 additional group therapy visits if pre-approved	$15 per group therapy visit
Emergency Services	$50 per visit (waived if admitted directly to **hospital**.

RULES OF ELIGIBILITY UNDER PLAN B

ARTICLE I. ELIGIBILITY RULES

Employees of **Contributing Employers**, and their eligible **Dependents**, who work within the jurisdiction of and under the terms of the collective bargaining agreements creating the San Diego Electrical Health and Welfare Trust, and are presently covered in **Plan B**, will remain covered in accordance with Article II. All other **Employees**, and their enrolled eligible **Dependents**, will become covered in accordance with the terms outlined in Article III. In the event a **Bargaining Employee** dies after accruing 260 hours within a twelve month period or less, and prior to the date his coverage would otherwise have taken effect, coverage for the **Bargaining Employee** only shall be deemed to have commenced as of the **Bargaining Employee's** last day of work.

Commencing June 1, 2011, certain **Non-Bargaining Employees** as described in Section III, Article I of the "ELIGIBILITY FOR NON-BARGAINING EMPLOYEES" may participate in Plan B Kaiser as outlined in ARTICLE XI . All other provisions pertaining to **Non-Bargaining Employees** coverage shall apply to the **Non-Bargaining Employees** described in Section III, Article I. **Non-Bargaining Employees** described in Section III, Article I, shall have the ability to add Dependents to their coverage. However, **Non-Bargaining Employees** participating in **Plan B** shall only be permitted to change to **Plan A** by making a timely election to do so as part of a scheduled annual open-enrollment period and then satisfying all initial qualifying requirements under **Plan A**.

Further, if the **Non-Bargaining Employee** is age 70 or older as of the effective date of his initial coverage as a **Plan B** participant, he will not be eligible for any life insurance benefits which may be provided by or be available through the **Plan**.

ARTICLE II. CONTINUED ELIGIBILITY

The employment records of all **Bargaining Employees** will be reviewed on a monthly basis to determine whether a **Bargaining Employee** is eligible for continued coverage by satisfying their minimum hourly requirement for the appropriate cost of coverage based on the type of coverages, in effect at the time, as elected by the **Employee**. Each **Bargaining Employee** will remain covered through the third month following that month in which the minimum hourly requirement is satisfied by virtue of any combination of hours worked for **Contributing Employers** and/or existing in his Reserve Account (see Article VI.). However, any **Bargaining Employee** who becomes employed by a Non-**Contributing Employer** will not be permitted to remain covered as of the end of the month in which such employment commenced. In such an event, all hours existing in his Reserve Account as of the last day of said month shall be frozen in accordance with Article VI. In such an instance the only basis for continuing coverage will be in accordance with the Rules for Continuation Coverage Following Termination under COBRA.

The minimum hourly requirement for coverage for the **Bargaining Employee** only and consisting of Kaiser medical benefits with basic life insurance and MAP benefits is 144 hours per month. The additional hourly requirement for **Plan B Kaiser Medical** and MAP Benefits for the first **Dependent** and/or additional **Dependent(s)** to be covered are 144 and 117, respectively. The hourly requirement for coverages consisting of the same supplemental life insurance benefits or dental/vision benefits available to **Plan A** participants may differ, depending upon the combination of benefits elected by the **Bargaining Employee**, and the **Bargaining Employee** will be charged or credited accordingly.

ARTICLE III. INITIAL ELIGIBILITY

New **Bargaining Employees** are defined as those who are not presently eligible for coverage under **Plan B** in accordance with Article I. A New **Bargaining Employee** will become eligible on the first day of the second month following the month in which a minimum of 260 hours have been reported in his name by **Contributing Employers** during any twelve consecutive calendar months, or less. However, hours reported by a **Contributing Employer** which had already been credited toward a month of coverage may not be included in satisfying the minimum hours requirement for Re-qualification under this Article.

Coverage of a newborn dependent **Child** shall take effect on the date of birth, adoption or placement for adoption of such **Child** if the appropriate election of **dependent** coverage had been made by the **Bargaining Employee** or within 30 days of their birth in accordance with HIPAA and upon payment of all required additional costs of coverage; however, such coverage for routine nursing care or well-baby care, immunizations, examinations or tests not connected with injury, illness, congenital defects or birth abnormalities shall be payable in accordance with the Schedule of Benefits for **Plan B** coverage.

ARTICLE IV. TERMINATION

A review of the hours reported for each **Bargaining Employee** will be made on a monthly basis. Eligibility for the **Bargaining Employee** will terminate if the **Bargaining Employee** has not accumulated a minimum of 144 hours during the corresponding work month described in Article II. or, if applicable, the minimum hourly requirement commensurate with the appropriate cost of the **Employee's** Coverage. Eligibility for the **Bargaining Employee's Covered Spouse and/or Dependent Child(ren)** will terminate if the **Bargaining Employee** has not accumulated the required minimum number hours during the corresponding work month described in Article II. or, if applicable, the minimum hourly requirement commensurate with the appropriate cost of the **Covered Spouse and/or Dependent Child(ren)'s** Coverage. Notwithstanding the provisions of Article II., or any other Articles of these Rules of Eligibility, an **Employee** otherwise eligible for coverage shall be immediately terminated as a **Covered Employee** if that person is no longer employed by, or available for full-time work by, a **Contributing Employer**, except this condition shall not apply to any **Employee** who cannot work due to a **Disability** or retirement. A person shall be presumed to be unavailable for full-time work by a **Contributing Employer** if that person is employed full-time performing work at the trade for a Non-**Contributing Employer**.

The coverage of the **Covered Person** shall terminate: (1) on the date the **Covered Person** ceases to be eligible for coverage; (2) on the date the **Covered Person**, if a **Dependent**, ceases to be a **Dependent**; (3) upon the **Covered Person** failing to make any necessary **Direct Payment** by the due date; or (4) upon the death of the **Covered Employee**; or (5) upon termination of the Plan.

In the event a retired **Covered Employee**, or their **Dependent Spouse,** has remained covered through the use of post-retirement hours and becomes entitled to Medicare, their individual coverage in the **Plan** will terminate effective with the first day of the month their Medicare coverage becomes effective. If the retired **Employee's** Medicare entitlement precedes that of their **Spouse**, this will constitute a qualifying event for their **Spouse** in accordance with the Rules for Continuation Coverage Following Termination under COBRA.

However, when a retired **Covered Employee's** primary residence falls outside any geographic area where current Plan C Kaiser coverage is generally available, if the retired **Covered Employee** qualified for subsidized Plan C deductions at the time their pension benefit commenced then they will be entitled to receive the same amount of monthly subsidy afforded to a Medicare eligible Plan C participant receiving the same amount of pension benefit upon submission of a receipt confirming their payment of a Medicare supplemental premium.

ARTICLE V. RE-QUALIFICATION

An **Employee** whose eligibility has been terminated may only re-qualify for coverage as a New Employee in accordance with Article III. However, a retired **Employee** who engages in permitted post-retirement employment may not use those hours to qualify for Plan A coverage or to reinstate Plan A coverage that had been terminated prior to or at any time after the effective date of their monthly benefit from the San Diego Electrical Pension Trust. All contributions received for such post-retirement employment shall be recognized as **Plan C** contributions and may only be utilized if the **Retiree** and/or their **Spouse** become covered under **Plan C** in accordance with the Rules of Eligibility For **Retirees** Under **Plan C**.

In the event a former **Covered Employee** has retired, but performs post-retirement employment as permitted by the San Diego Electrical Pension Plan Document, if their **Plan A** coverage has not been continuous since the date of their retirement they will not be permitted to re-qualify for **Plan A** coverage so long as they continue receiving monthly payments from the San Diego Electrical Pension Plan.

ARTICLE VI. RESERVE ACCOUNT

Once a **Bargaining Employee** has established his initial eligibility for coverage under Article I., he may accumulate hours in his Reserve Account by virtue of the amount of hours reported by **Contributing Employers** on a monthly basis to the extent that his reported hours in a given month exceed his cost of coverage for the corresponding month of coverage up to a maximum of 1,000 hours. Any accrued Reserve Account hours in excess of the maximum will revert to the **Trust**.

In accordance with Article IV. a charge against each **Bargaining Employee's** Reserve Account will be made, if necessary, to satisfy the cost of coverage for the appropriate month of coverage. In the event the combined total of hours reported by **Contributing Employers** and/or existing in the Reserve Account is insufficient to cover the cost of coverage, then all such hours may be credited against said cost of coverage and the balance may be paid in the form of a **Direct Payment** as provided in Article VII. If the **Bargaining Employee** fails to remit the **Direct Payment** on a timely basis, then all such hours shall revert to his Reserve Account to be used only upon satisfaction of Initial Eligibility in accordance with Article III.

Notwithstanding the provisions of this Article, a **Bargaining Employee's** Reserve Account shall be frozen if the person is no longer employed by or available for full-time work for a **Contributing Employer**, except this condition shall not apply to any **Bargaining Employee** who cannot work due to a **Disability** or retirement. A person shall be presumed unavailable for full-time work by a **Contributing Employer** if that person is either self-employed, employed part-time or full-time at any occupation for wages or profit for other than a **Contributing Employer** is not enrolled and eligible for work on the "out-of-work" book of the **Union**. In the event a **Bargaining Employee's** Reserve Account is frozen in accordance with Articles III. and IV., and he does not re-qualify for coverage in accordance with Article V. of these Rules within 12 calendar months from the first day of the month in which his Reserve Account hours were frozen, all such hours shall be forfeited.

ARTICLE VII. DIRECT PAYMENTS

Direct Payments shall be made in such amounts and manner as prescribed by the **Trustees**. Each **Bargaining Employee**, upon being terminated from coverage in accordance with Article IV., shall be permitted to remit **Direct Payments** as a means of maintaining coverage for himself and his **Covered Dependents** for each month he failed to satisfy the applicable cost of coverage provided, however, that the **Employee** worked at least 1 hour for a **Contributing Employer** in the corresponding work month.

In the event the **Employee** fails to work at least 1 hour for a **Contributing Employer** in the corresponding work month the only means of maintaining coverage for himself and his **Covered Dependents** will be through the use of any Reserve Account hours and/or pursuant to the Rules for Continuation of Coverage Following Termination under COBRA. However, in the further event the **Employee** completes twelve consecutive calendar months without receiving credit for at least 50 hours of **Covered Employment** the twelve corresponding **Direct Payments** will be recognized as being the first twelve payments under COBRA.

All Reserve Account hours will first be credited in determining the continued eligibility prior to acceptance of a **Direct Payment**. In the event a **Bargaining Employee** fails to make the required **Direct Payment**, eligibility will be terminated, all applicable Reserve Account hours will revert back to the **Employee's** Reserve Account, and the **Bargaining Employee** may only re-qualify his eligibility as a New **Bargaining Employee** in accordance with Article III.

All **Direct Payments** are due to be received by the Trust Office by the 15th day of the month for which coverage has been terminated, and in no event later than 30 days after the first day of said month.

Notwithstanding the provisions of this Article, no **Direct Payment** shall be allowed if the **Bargaining Employee** is no longer employed by, or available for full-time work by, a **Contributing Employer**, except this condition shall not apply to any **Bargaining Employee** who cannot work due to a **Disability.** A **Bargaining Employee** shall be presumed to be unavailable for full-time work by a **Contributing Employer** if that **Employee** is not enrolled and eligible for work on the "out-of-work" book of the **Union** and/or is employed full-time performing work at the trade for a Non-**Contributing Employer**.

ARTICLE VIII. DISABILITY

For the purpose of maintaining eligibility in accordance with Article II, a **Bargaining Employee** who becomes **Disabled** while covered by this **Plan**, and who is not eligible for coverage under **Plan C**, shall receive Disability Credit for each consecutive Month of Proven **Disability** for up to a maximum of 12 consecutive months, subject to the following conditions:

(a) The **Bargaining Employee** must initially sustain at least 30 consecutive days of **Disability** prior to becoming eligible to receive any Disability Credit.

(b) In the event a **Bargaining Employee** becomes **Disabled** and has single coverage their Reserve Account will be frozen, except as provided in item (c) until he/she is no longer eligible to receive Disability Credits or they have received the maximum number of Disability Credits. However, if the **Bargaining Employee's Eligible Spouse** and/or **Dependent Child(ren)** are covered at the time Disability Credits shall become applicable to their coverage any remaining Reserve Account hours may continue to be utilized for the purpose of maintaining their continuous coverage.

(c) If the hours existing in the Reserve Account during the initial 30 days of **Disability** are insufficient to cover his full cost of coverage, the **Bargaining Employee** must pay the balance in the form of a **Direct Payment** in order to maintain continuous coverage. This requirement will continue until the application of the first month of Disability Credit toward the cost of coverage for the first month of proven **Disability**.

(d) A month of proven **Disability** shall be any calendar month, after the initial 30-day period, during which the **Bargaining Employee** is **Disabled** for at least 20 calendar days.

(e) The **Bargaining Employee** shall receive Disability Credit for each month of proven **Disability** in the amount necessary to satisfy the hourly requirement of the cost of coverage for single coverage consisting of whichever benefits he had previously elected or may elect in a subsequent Annual Enrollment process other than to add supplemental life insurance.

(f) A period of **Disability**, for the purposes of this Article, shall be continuous unless the **Bargaining Employee** is no longer **Disabled** and is released by their Physician so as to become available to return to full-time employment for a **Contributing Employer** or if a subsequent **Disability** is totally unrelated to the previous **Disability** for which Disability Credit was awarded.

For the purposes of this Article the term "full-time employment" shall mean the **Bargaining Employee** has been cleared by their attending **Physician** to resume the regular duties of their job and the **Employee** completes five (5) consecutive regularly scheduled days or 40 consecutive hours of regularly scheduled work for a **Contributing Employer**.

In the event the **Disability** continues longer than 12 consecutive months the subsequent termination from coverage shall be considered a qualifying event for Continuation Coverage Following Termination under COBRA. Further, if a **Covered Employee** becomes **Disabled** during a period of Continuation Coverage under COBRA then each month of Disability Credit will count as one month of COBRA coverage. In no event will a **Disabled Employee's** coverage be continued, by virtue of Disability Credits, past the maximum period of coverage permitted in accordance with the Rules for Continuation Coverage Following Termination under COBRA.

ARTICLE IX. ARMED FORCES

Coverage in the **Plan** shall be terminated for an **Employee**, and his **Covered Spouse** and/or his **Covered Dependent Child(ren)**, if applicable, on the date the **Employee** voluntarily enlists or is called to full-time active duty in the **Armed Forces** of the United States of America, while any hours remaining in his Reserve Account shall be frozen during the period of such active duty. However, as noted below, if the **Employee** does not notify the **Plan** prior to actual entry into active duty then all hours existing in their Reserve Account as of the date their active duty commences will continue to be applied toward maintaining continuous coverage for themself and their **Covered Spouse/Child(ren)**, if applicable, and may not be frozen to be applied to subsequent coverage upon their being discharged. Coverage for **Employees** who provided the Plan with timely notice of the commencement of their active duty, and their **Covered Dependents**, if applicable, who are discharged from the Armed Forces will be reinstated, along with any remaining frozen Reserve Account hours, on the date they are re-employed by a **Contributing Employer**, if they secure such re-employment within 90 days after their discharge from the **Armed Forces** or within 90 days after their discharge from a **Hospital** if they are hospitalized at the time of their discharge from the **Armed Forces**, or make proper application for employment on the **Union's** "out of work" book. It is the responsibility of any such **Employee** to advise the Trust Office immediately of their entrance into the **Armed Forces** prior to actual entry and, similarly, immediately upon their discharge. Failure to do so shall terminate all eligibility for benefits, while also resulting in the forfeiture of all Reserve Account hours and eligibility to remit **Direct Payments** upon induction into the **Armed Forces**. Any claim for benefits made by an **Employee** who re-establishes his eligibility under this Article shall be subject to the Coordination of Benefits provision of this **Plan**. However, the **Covered Employee** and/or any **Covered Dependent** may elect to continue their coverage for up to 24 months in accordance with USERRA. If you do not elect USERRA coverage, your **Covered Dependents** can elect COBRA coverage. USERRA and COBRA coverage shall run concurrently.

ARTICLE X. DEPENDENTS OF DECEASED EMPLOYEES

Benefits for the **Covered Spouse and/or Dependent Child(ren)** of a deceased **Covered Employee** who are covered by the **Plan** as of the **Employee's** date of death will continue for the period of time during which the **Employee's** Reserve Account hours would have been sufficient to continue such coverage had he not died. Such coverage shall include utilization of all Reserve Account hours which the deceased **Employee** had accumulated. There will be no provision for continuation of coverage beyond that date under the **Plan**, except as provided under Continuation Coverage Following Termination Under COBRA.

ARTICLE XI. PLAN B MEDICAL BENEFITS

All **Covered Employees** working under a Collective Bargaining Agreement providing for participation in **Plan B**, and their eligible **Dependents,** who qualify for coverage will be covered under a newly created **Plan B**. Medical benefits will be provided under a separate contract with Kaiser, with the same Members' Assistance Program ("MAP") and basic life insurance and basic life insurance/AD&D benefits as under **Plan A.** The same dental/vision and supplemental life insurance benefits available to **Plan A** participants will be optional.

CONTINUATION OF COVERAGE FOLLOWING TERMINATION FROM PLAN B. Following termination from coverage under **Plan B** each **covered person** may be entitled to maintain their coverage in accordance with the "Rules for Continuation Coverage Following Termination" contained in the **Plan A** eligibility section of this Summary Plan Description (see page 32).

PLAN C

SCHEDULES OF BENEFITS FOR PLAN C KAISER (HMO)

The basic premise of an HMO plan is that the **Covered Person** receives most services at no out-of-pocket expense so long as recognized **Hospitals** and **Providers** are utilized. However, in some instances there are co-payments required to be paid on a fee for service basis. The following is a brief description of the current Schedule of Benefits, while all pertinent information is contained in the brochure "*Your Health Plan Coverage"* published by Kaiser Permanente, available at the Trust Office. **Please note there are separate schedules for non-Medicare and Medicare eligible participants.**

FOR NON-MEDICARE RETIREE AND DEPENDENTS:

Type of Service	**Co-payment**
Hospital	
• All Services including Physician services	No Charge
Physician	
Professional	
Type of Coverage	**Co-payment**
• Office Visits, physicals, vision and hearing exams, well child care, therapy, prenatal visits & 1st postnatal visit	$10 per visit
• Laboratory, x-ray, diagnostic tests, allergy tests	No Charge
Ambulance - Within service area	No Charge
Home Health Care	No Charge
Hospice Care	No Charge
Skilled Nursing Care	
• Up to 100 days per calendar year	No Charge
Prescriptions	
• Covered Prescriptions - Generic	$5 per prescription (Up to 100-day supply)
	$20 per prescription (Up to 100-day supply)
• Covered Prescription - Brand Name or compounded products	50% of charges (27 doses in any 100-day period)
• Drugs for the treatment of sexual dysfunction disorders as prescribed by Plan Physicians	
Alcoholism/Substance Abuse	
• Inpatient Detoxification	No Charge
• Transitional residential recovery services (60 days per calendar year not more than 120 days in a 5-year period)	$100 per admission
• Outpatient Individual Therapy	$10 per visit
• Outpatient Group Therapy visits	$5 per visit

Mental Health Care	
• Up to 45 days of **hospital** care	No charge
• For the first 20 out-patient visits per calendar year (individual or group)	$10 per visit
• Up to 20 additional group therapy visits if pre-approved	$ 5 per visit
Emergency Services	$50 per visit (waived if admitted directly to **hospital**)
Hearing Aids	
• One hearing aid per ear every 36 months	$2500 allowance per aid

MEDICARE RETIREE AND DEPENDENTS:

Type of Service	**High Plan Co-payment**	**Low Plan Co-payment**
Hospital		
• All Services including Physician services	No Charge	$200 per admission
Physician		
• Office Visits, physicals, vision and hearing exams, well child care, therapy, urgent care visits	$10 per visit	$20 per visit
• Laboratory, x-ray, diagnostic tests, allergy tests	No Charge	No Charge
Ambulance - Within service area	No Charge	No Charge
Home Health Care	No Charge	No Charge
Hospice Care	No Charge	No Charge
Skilled Nursing Care		
• Up to 100 days per benefit period	No Charge	No Charge
Prescriptions		
• Prescriptions -Generic	$5.00 per prescription (Up to 100-day supply or 3 cycles for oral contraceptives) or	$10.00 per prescription (Up to 100-day supply) or
• Prescriptions- Brand or compounded products	$15.00 per prescription (Up to 100-day supply or 3 cycles for oral contraceptives) or	$25.00 per prescription (Up to 100-day supply) or
• After the participant pays $4,550 for Part D drugs	Not Applicable	No coverage for brand names and 93% toward the cost of generic drugs

Type of Service	High Plan Co-payment	Low Plan Co-payment
Alcoholism/Substance Abuse		
• Inpatient Detoxification	No Charge	$200 per admission
• Transitional residential recovery services (60 days per calendar year not more than 120 days in a 5-year period)	$100 per admission	$100 per admission
• Outpatient Individual Therapy	$10 per visit	$20 per visit
• Outpatient Group Therapy visits	$5 per visit	$5 per visit
Mental Health Care		
• 190 lifetime inpatient days at a Medicare-certified facility, thereafter 45 days per calendar year.	No charge	$200 per admission
• Outpatient Services	$10 per visit	$20 per visit
Emergency Services		
• In Southern California service area	$10 per visit (waived if admitted directly to **hospital**)	$50 per visit (waived if admitted directly to **hospital**)
Hearing Aids		
• One hearing aid per ear every 36 months	$2500 allowance per aid	$2500 allowance per aid

If the **Retiree** and/or their **Covered Dependent** is eligible for Medicare it is possible to elect Kaiser's "Senior Advantage" Plan meaning that their Medicare coverage is solely provided through Kaiser Permanente and that only Kaiser facilities are to be utilized. In the absence of making a "Senior Advantage" election, the additional premium surcharge will be added to the monthly deduction. There are nominal differences to the above Schedule of Benefits to the extent there are fewer services where co-payments are applicable or co-payments would be less than under this **Plan** . These benefits are more specifically outlined in *"Your Health Plan Coverage"*.

RULES OF ELIGIBILITY FOR RETIREES UNDER PLAN C

A **Retiree** and his **Covered Dependents** are eligible to participate in **Plan C** if one of the following conditions is satisfied:

1. If the **Retiree** was eligible for coverage under **Plan A** for the month immediately prior to the date of his retirement or disability, and if the **Retiree** satisfies the definition of "**Retirement**" or "**Disability**" contained in these Rules of Eligibility: or
2. If a **Retiree** was eligible under **Plan A** in 84 out of the 120 months prior to the effectuation of his monthly pension benefit from the San Diego Electrical Pension Plan or the cessation of contributions by **Contributing Employer(s)** on his behalf, provided he shall not have worked at the electrical trade or craft in any capacity since the cessation of contributions.; or
3. The **Retiree** has a combined total of at least 20 years of **Plan A** coverage, provided the **Retiree** was covered in **Plan A** for at least the 60 months immediately preceding the date his/her **Retirement** or **Disability** under the San Diego Electrical Pension Plan; or
4. If the participant has been covered in **Plan A** for at least 84 of the 120 months immediately preceding his/her retirement from the electrical industry, craft or trade, but will not be otherwise eligible to receive a pension benefit

from the San Diego Electrical Pension Plan because some or all of his/her pension hours had been transferred back to his/her Home Fund, he/she may participate in **Plan C** on a non-subsidized basis**.** However, his/her participation is subject to verification that the participant will be receiving a pension from his/her Home Local's Pension Plan and that he/she would have qualified for **Retiree's** coverage in his/her Home Health & Welfare Plan as of that date if his/her hours had been transferred to his/her Home Fund. If there is no **Retiree's** coverage through his/her Home Local's Health & Welfare or Pension Plans then satisfaction of the above 84 out of 120 month criteria will qualify the participant for **Plan C** coverage.

Definition of Retirement. The **Retiree** is age 55 or over and is receiving either a Normal or Early Retirement Pension from the San Diego Electrical Pension Trust.

Definition of Disability. The **Retiree** is receiving a Disability Retirement Pension from the San Diego Electrical Pension Trust.

It will be permissible for a **Covered Employee**, who retires and is eligible to participate in **Plan C**, to maintain coverage for himself, and his **Covered Dependents**, in **Plan A** by virtue of exhausting his Reserve account and remitting the maximum number of **Direct Payments** and/or Continuation Coverage payments provided for in the **Plan**. However, a **Retiree** who works in covered employment in California, as permitted in the Pension Plan, may only receive credit for those hours to maintain continuous **Plan A** coverage commencing on their date of retirement , but not toward reinstating or re-qualifying for **Plan A** coverage if there has been a subsequent termination from **Plan A** coverage.

At that time application for coverage under **Plan C** must be submitted to the Trust Office. However, the **Retiree** may transfer coverage for himself and his **Covered Dependent(s)** to **Plan C** at any time prior to his remitting the maximum number of **Direct Payments** and/or Continuation Coverage payments permitted under Section I. of this **Plan** provided there is no interruption in coverage.

Premiums. The amount of premium to be charged each month will be in the amount prescribed by the **Trustees** and will automatically be deducted from the **Retiree's**/**Beneficiary's** monthly pension benefit check provided the net amount of their check is sufficient to cover the total premium due. Any balance due must be received by the Trust Office by no later than the last day of the month for which the premium is due. At present, premium will be charged as follows:

1. If the **Retiree** was covered under **Plan A** for at least 84 of the 120 months immediately preceding his date of retirement, or if the **Retiree** was covered under **Plan A** for at least 240 months (of which 60 must be immediately preceding their date of retirement), he will qualify for the subsidized cost of coverage established by the **Trustees**.

2. If the **Retiree** does not satisfy the criteria in (a) above, then he will be billed the entire premium charged to the **Trust** or as established by the **Trustees**;

   RETIREE COVERAGE WHICH IS SUBSIDIZED BY THE **TRUST**, AS PROVIDED UNDER THIS **PLAN**, IS ON A MONTH-TO-MONTH BASIS TO THE EXTENT THAT CONTRIBUTIONS THROUGH **CONTRIBUTING EMPLOYERS** TO THE **TRUST** PERMIT. **RETIREE** COVERAGE, WHICH IS SUBSIDIZED, IS NOT SUPPORTED BY ANY LONG RANGE RESERVE FUNDING PROGRAM. THE **BOARD OF TRUSTEES** RESERVE THE RIGHT TO MODIFY OR DISCONTINUE ENTIRELY THE SUBSIDY AND/OR COVERAGE PROVIDED FOR **RETIREES** AND/OR THEIR **COVERED DEPENDENTS** AS CIRCUMSTANCES MAY WARRANT.

3. If the **Retiree** or his **Covered Dependent** is/are eligible to be covered by Medicare, and either did not enroll on a timely basis or is not covered by Medicare for any reason, the **Retiree** or his **Covered Dependent** (if a beneficiary) will be responsible for paying the full amount of any premium surcharge imposed on the **Trust** in addition to their monthly deduction for coverage(s) in **Plan C**; or

4. A **Retiree** may use any existing Reserve to satisfy his monthly cost of coverage. A Reserve under **Plan C** may be established by converting any **Plan A** Reserve account hours existing as of the end of the last month of such coverage into a dollar equivalent, recognizing the **Plan A** portion of the current overall contribution rate under the Inside Wiremen's Agreement, as well as the amount of contributions received on the **Retiree's** behalf for post retirement work in covered employment.

   A **Retiree** may elect to have his **Plan A** Reserve Account hours converted into a **Plan C** reserve to become immediately applicable to maintain continuous **Plan C** coverage or the reserve amount may be frozen for use at a later time upon re-entering **Plan C** as may be permitted under these Rules of Eligibility. However, whether due to a conversion of **Plan A** Reserve Account hours at retirement or in conjunction with post-retirement employment, at no time may a **Retiree's Plan C** reserve exceed an equivalent value in excess of the then current maximum of **Plan A** Reserve Account hours multiplied by the then current **Plan A** Direct Payment contribution rate. As of January 1, 2012 this maximum amount is $5,670.00 (1,000 hours @ $5.67/hr).

Any **Retiree** or **Covered Dependent** who is eligible for, and has enrolled in, Medicare may elect to be covered under a less expensive alternate schedule of medical benefits in conjunction with an open-enrollment period preceding each January 1st and July 1st. There shall be no interim change between recognized Medicare coverages other than in accordance with an authorized open-enrollment process.

Initial Eligibility. The **Retiree's** coverage will become effective on the first day of the month following receipt of the **Retiree's** application for coverage and the satisfaction of the first month's cost of coverage in the form of a premium payment or use of any existing Reserve account hours.

In the event a **Retiree**, who qualifies for participation in **Plan C** as of the date his/her pension benefits commence, wishes to delay participation in **Plan C** for his/herself and/or his/her **Dependent(s)** who were covered in **Plan A** as of the date **Plan A** coverage\terminated, it will be permissible to defer commencement of **Plan C** coverage if the **Retiree** or their dependents submit satisfactory proof of continuous group medical coverage through another group health plan or through their **Spouse's** employer. However, unless participation in Plan C is delayed as set forth in the preceding sentence it will not be permissible for a **Retiree** and/or their eligible **dependent(s)** to become covered under **Plan C** at a later date if **Plan C** coverage is declined on behalf of the **Retiree** and/or any of their eligible **dependents** as of the date such coverage would otherwise have become effective in conjunction with the **Retiree** commencing receipt of retirement benefits under the San Diego Electrical Pension Plan or transferring coverage from **Plan A** to **Plan C** as permitted in these Rules of Eligibility.

In addition, if a **Retiree** predeceases their **Spouse**, the **Retiree's Spouse** and all eligible **Dependents** as of the date **Plan A** coverage terminated will be permitted to return to **Plan C** upon submission of satisfactory proof of their continuous coverage in another group health plan or the **Spouse's** group health plan. In the event the **Spouse** were to remarry, their new **Spouse** and/or any person(s) becoming a **Dependent** after the **Retiree's Plan A** coverage terminated will not be permitted to become covered under **Plan C** under any circumstances.

Re-employment Enrollment. If the **Covered Retiree's** coverage is terminated because he became re-employed in any capacity so that he no longer qualified as "Retired," and he then re-retires, he must submit a new application for coverage and first month's advance premium payment. However, if the **Retiree** becomes re-employed, as noted above, at any time for a non-signatory Employer he will not be eligible to apply for requalification of this coverage.

Termination of Eligibility. The eligibility of a **Covered Retiree**, and his **Covered Dependents**, for coverage under **Plan C** will terminate upon the first of the following:

a. **Plan** Termination. The date upon which coverage known as **Plan C** is terminated by the **Trustees**.

b. Non-payment. The **Covered Retiree** fails to make premium payments on a timely basis in the prescribed amount. Eligibility will immediately terminate when a premium payment becomes past due, and the **Retiree** shall have no right of requalification for coverage under **Plan C** except upon approval of the **Trustees**. The **Trustees** reserve the right to deny for any reason(s) the request for requalification from any previously **Covered Retiree** whose coverage was terminated due to non-payment of premium.

c. Re-employment. If a **Covered Retiree** becomes re-employed in any capacity resulting in his no longer being "Retired", as defined by the San Diego Electrical Pension Trust, the **Covered Retiree** will have to submit a new application to again become eligible for coverage under **Plan C** upon his re-qualifying as "Retired", subject to the terms noted under "Re-employment Enrollment" above.

d. Death of Retiree. In the event a **Covered Retiree** dies his **Covered Dependent(s)** may continue to be covered under **Plan C** provided all premiums due are paid on a timely basis and there is no interruption in coverage. Further, it will not be permissible for any **Dependent** of the **Covered Retiree** or their **Covered Dependent**, where such **Dependent** was not covered at the time of the **Retiree's** death, to be added as a **Covered Dependent** at any time. An unmarried or widowed **Covered Retiree** may add a new **Spouse** as a **Covered Dependent** and any **children** who meet the definition of an **Eligible Dependent** under **Plan A**. However, a surviving **Spouse** of a deceased **Retiree** who was covered under **Plan C** at the time of the **Retiree's** death may maintain coverage for themself only and may not add a new **Spouse** or their children as **Covered Dependents** under **Plan C**.

   In the event that **Plan C** coverage for a **Retiree** and/or any **Dependent** is terminated for any reason, their re-entry into **Plan C** will not be permitted at any time in the future.

e. Fraud. If it is determined that coverage became effective due to a fraudulent or intentional misrepresentation of material facts or information that would otherwise have prevented the **Covered Person** from becoming covered under the **Plan**.

f. COBRA Continuation Coverage. Upon termination of coverage under these Rules of Eligibility there shall be no means by which the **Retiree** and/or any **Covered Dependent(s)** may maintain coverage under Continuation Coverage Following Termination under COBRA.

VOLUNTARY RETIREES' DENTAL BENEFITS

Effective January 1, 2008 voluntary dental insurance through Delta Dental will be available to any **Retiree** and/or **Dependent** upon their completing the required enrollment form and authorizing appropriate deduction of the monthly premium from their monthly pension payment. However, access to this coverage requires that the **Retiree** or their Surviving **Spouse** is receiving a monthly pension payment from the San Diego Electrical Pension Trust in an amount sufficient to cover the full cost of their dental coverage. In the event a **Retiree** or Surviving **Spouse**'s monthly pension payment becomes insufficient to cover their monthly dental premium, continued coverage must be arranged with Delta Dental provided the continuation of such dental coverage is permissible under the then current Delta Dental contract.

There are presently two dental plans available subject to the geographic limitations and availability of participating providers. The monthly composite premiums (single or family coverage) are as follows:

HMO (Only in California) - $ 41.21

PPO (Nationwide - $ 67.00

The schedule of benefits and monthly premium amount for either plan may be subject to change by Delta Dental and/or the **Trustees** at any time. A comparison of the two benefit programs is as follows:

BENEFITS AND COVERED SERVICES	DeltaCare DHMO	PPO In Network	PPO Out of Network
DEDUCTIBLES	**0**	**$50**	**$50**
ANNUAL MAXIMUM	**0**	**$1,250**	**$1,000**
WAITING PERIOD(S)	**None**	**12 months for Major Procedures**	**12 months for Major Procedures**
DIAGNOSTIC & PREVENTIVE BENEFITS (**Deductible Waived**) -- Oral examinations, routine cleanings, x-rays, fluoride treatment, space maintainers, specialist consultations	**No Cost**	**100%**	**100%**
BASIC BENEFITS -- Fillings, sealants, simple extractions	**No Cost - $95**	**80%**	**80%**
MAJOR BENEFITS* -- tissue removal (biopsy), surgical extractions, root canals, periodontics (gum treatment), crowns, inlays, inlays and cast restorations	**No Cost - $420**	**50%**	**50%**
PROSTHODONTICS* -- Bridges, partial dentures, full dentures	**No Cost - $350**	**50%**	**50%**
ORTHODONTIC BENEFITS -- adults and eligible children	**$1600 (Child) $1800 (Adult)**	**None**	**None**

* After 12 Months continuous coverage

PART TWO

DEFINITIONS

"Accidental Injury" or "Bodily Injury" means observable body damage or pain resulting from a sudden and unforeseeable event; a direct trauma from instantaneous contact with an outside force, object or substance when such results have not been intentionally self-inflicted. Neither cumulative trauma or injury sustained as a result of a natural body movement are an **accidental injury** under this definition.

"Allowable Charge(s)" means the maximum amount to be allowed as **Eligible Expense** for services rendered by a **Provider** (**Hospital** or **Physician**) under contract with the Blue Cross or the Plan's designated PPO provider. This amount will also apply to charges for services rendered by **Physicians** who are located in the geographic area serviced by the PPO but are not under contract with the PPO.

"Armed Forces" means active duty in any military, naval or Air Force; but active duty as a member of a reserve component of the **Armed Forces** of the United States of America for a training period not exceeding one month shall not be considered "military service" until the expiration of such training period or one month, whichever is less.

"Bargaining Employee" means an **Employee** employed in a job classification covered by a collective bargaining agreement between his **Contributing Employer** and the **Union** which requires contributions to be made to this **Trust**.

"Contributing Employer" or **"Employer"** means any **Contributing Employer** who is required or permitted to make contributions to this **Trust**, as well as all Trust Funds remitting contributions pursuant to the Electrical Industry Health and Welfare Reciprocal Agreement and/or any other related party remitting contributions pursuant to the terms of a Participation Agreement with this **Trust**.

"Covered Child" or **"Covered Children"** means the **Unmarried Dependent Child** of a **Covered Employee** ,**Covered Retiree** or **Domestic Partner** who is under age 26.

The term **"Child"** includes a **Covered Employee's**, **Covered Retiree's** or **Domestic Partner's** natural child, stepchild, legally adopted child, eligible foster child, and child under legal guardianship of a **Covered Employee**, **Covered Retiree** or **Domestic Partner**. The term **"Covered Child"** shall also include a surviving **Dependent Child** of a deceased **Covered Employee**, **Covered Retiree** or **Domestic Partner** who remains eligible to receive benefits under this **Plan,** However, the term shall not include the surviving **Dependent Child's Spouse** or natural child, stepchild, legally adopted child, eligible foster child and/or child under legal guardianship.

In order for a **Child** to be considered a **Dependent Child** a copy of the **Child's** birth certificate and/or all pertinent legal papers must be provided to the Trust Office as well as completion of any required attestation as to the accuracy of all declared **Dependent Children**. The appearance of a **Child's** name on an Enrollment Card will not automatically qualify the **Child** as a **Dependent** of a **Covered Employee**, **Covered Retiree** or **Domestic Partner**.

"Covered Dependent" means any one of the following persons who are not employed by any **Contributing Employer** and who are covered under the **Plan**:

A. The **Covered Employee's** or **Covered Retiree's Spouse** to include the surviving **Spouse** of a deceased **Covered Employee** or **Covered Retiree** to the extent the **Covered Employee** or **Covered Retiree** would have remained eligible to be covered under this Plan, or **domestic Partner**.
B. If, on the date he attains the age at which his coverage under the **Plan** would terminate, an unmarried **Dependent Child** is **Totally Disabled** and incapable of self-sustaining employment by reason of mental retardation or physical handicap which commenced before such date, his coverage shall be continued in force during the period of such **Totally Disability**, provided (1) he was covered under the **Plan** immediately before the attainment of the termination age, and (2) the **Covered Employee** or **Retiree** submits to the **Plan** satisfactory proof of such incapacity within 31 days of such **Covered Child's** attainment of the termination age. The **Plan** may require, at reasonable intervals during the 2 years following the **Covered Child's** attainment of the termination age, subsequent proof of incapacity and dependency. After such 2 year period, the **Plan** may require subsequent proof not more than once each year.

The **Plan** reserves the right to have the **Dependent Child** examined by a **Physician** of the **Plan's** choice to determine the continued existence of the **Total Disability.**

Coverage shall cease on the earliest of:

1. The date the **Covered Child** ceases to be **Totally Disabled**; or
2. The 31st day following the date the **Plan** requests additional proof of dependency or **Total Disability**, if such proof is not furnished as requested; or
3. The **Covered Employee** or **Retiree** ceases to be eligible for coverage.

The term "**Dependent**" will include any person who is also eligible under this **Plan** as a **Covered Employee**, but will not include any person who is in full-time active service in the **Armed Forces**, military, naval or air service.

"**Covered Employee**" or "**Employee**" means any **Bargaining** or **Non-Bargaining Employee** who has established, and continues to maintain, eligibility under this **Plan**.

"**Covered Person**" means either the **Covered Employee**, **Covered Retiree** or a **Covered Dependent**.

"**Covered Retiree**" means a **Retiree** who has established, and continues to maintain, eligibility under this **Plan**.
"**Covered Spouse**" or "**Spouse**" means the person to whom a **Covered Employee** or **Covered Retiree** is legally married who has established, and continues to maintain, eligibility under this **Plan**. A marriage which has been legally consummated shall continue until that marriage has been terminated either by entry of a Judgment of Dissolution or Annulment. "**Covered Spouse**" or "**Spouse**" shall also include a **Domestic Partner** so long as the standard "Affidavit of Domestic Partnership" required by the **Plan** is in full effect.

"Custodial Care" means care which consists of services and supplies, including room and board and other institutional services, furnished to an individual primarily to assist him/her in personal hygiene and other activities of daily living, whether or not he/she is **Disabled**. These services and supplies are **Custodial Care** regardless of the practitioner or **provider** who prescribed, recommended or performed them.

"**Direct Payment**" means payments made directly by a **Covered Person** to this **Trust** in order to maintain eligibility in such manner and amount as prescribed by the **Trustees**.

"**Disability**" or "**Disabled**" means a **Bodily Injury** or an illness, including **pregnancy**, with respect to an **Employee** who, by reason of the **Disability**, is **Hospital** confined or prevented from engaging in any occupation for wages or profit for which the **Employee** is qualified by reasons of education or training or the normal activities of a person in good health of like age or sex. With respect to a **Retiree** or a **Dependent** that the **Retiree** or **Dependent** is, by reason of the **Disability**, prevented from either engaging in any occupation conducted outside of their residence for wages or profit or from engaging in substantially all of his normal activities of a person in good health of like age or sex.

"Domestic Partner" means a person who is eligible to file, and his filed, a Registration Form with the State of California pursuant California Family Code Section 297 and has been involved in a committed relationship for a minimum of 6 months as of the date the **Covered Employee** executes the standard "Affidavit of Domestic Partnership" required by the **Plan**.

"**Durable Medical Equipment**" means equipment which has a solely therapeutic value as determined by Pacific Foundation for Medical Care for the treatment and/or management of a **Covered Person's Disability**, can withstand repeated use and is of no value to nor utilized by individuals not under treatment by a **Physician** for said **Disability**.

"**Eligible Expense**" means only **Usual Customary and Reasonable** fees charged for **Medically Necessary** services and supplies. An **Eligible Expense** is considered to be incurred on the date the service or supply is rendered or obtained, not on the date the charge is billed.

"Emergency Care" means treatment provided at a **Hospital** immediately following an **Accidental Injury**, or the sudden and unexpected onset of symptoms of an illness or change in a condition requiring immediate medical or surgical care where the injury or symptoms are of sufficient severity to require **Immediate Hospital Level Care**, as determined by the **Plan's** designated service provider.

"**Employer Association**" means the SAN DIEGO CHAPTER, NATIONAL ELECTRICAL CONTRACTORS' ASSOCIATION, INC.

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

"**Hospital**" means a legally operated institution which is accredited as a **Hospital** by the Joint Commission on Accreditation of Hospitals, or is specifically recognized by the **Trustees**, which (1) has permanent, full-time facilities for bed care of five or more resident patients, (2) has a **Physician** in regular attendance, (3) provides 24 hours a day service by Registered Nurses, (4) maintains on its premises all of the facilities needed for the diagnosis and medical care and treatment of illness or injury, and (5) is not a rest home, nursing home, **Skilled Nursing Facility**, convalescent home, or a place for the aged or for alcoholics or drug addicts. The term "**Hospital**" also includes institutions licensed and regulated by the State which primarily provide for the treatment of mental and nervous disorders and substance abuse but only to the extent such treatment is covered by the **Plan**.

"Immediate Hospital Level Care" means care determined by the **Plan's** designated service provider to be required within twenty-four (24) hours following an **Accidental Injury** or the onset of symptoms of an illness, or a change in a condition requiring immediate medical or surgical care, which could not be safely and adequately provided other than at a **Hospital** or where adequate care is unavailable elsewhere in the immediate area at the time such care was needed.

"**In-patient**" means a **Covered Person** who is a resident patient using and being charged for the room and board facilities of a **Hospital** or a **Skilled Nursing Facility**.

"**Loss of Coverage**" means a **Covered Employee's** loss of continued eligibility for benefits due to the following:

A. In the case of a **Bargaining Employee**, it means that the **Bargaining Employee** has insufficient hours in his Reserve Account to satisfy the minimum hourly charge for coverage, and the **Bargaining Employee** fails to timely make, or is no longer eligible to make, **Direct Payments**. A **Loss of Coverage** shall occur if the **Bargaining Employee** continues in the employ of his Employer and his Employer is no longer signatory to a Collective Bargaining Agreement with the **Union**.

B. In the case of a **Non-Bargaining Employee**, it means that the **Non-Bargaining Employee** has insufficient hours in his Reserve Account to satisfy the minimum hourly charge for coverage. A **Loss of Coverage** shall occur if the **Non-Bargaining Employee** continues in the employ of his **Employer** and the **Non-Bargaining Employee's** coverage is terminated because his **Employer** fails to timely make payment of all contributions due to this **Plan** on behalf of its **Covered Employee**s, because his Employer is no longer signatory to a Collective Bargaining Agreement with the **Union** or because the **Non-Bargaining Employee** becomes covered under another group health plan provided through his **Employer**.

"**Medically Necessary**" means services and/or supplies which are determined to be reasonably necessary at the time treatment is rendered and are provided in accordance with generally accepted local community standards for care and treatment of illness or **Bodily Injury**. To be necessary, a service or supply must be: Ordered by a **Physician**, commonly and customarily recognized in the medical profession as appropriate in the treatment or diagnosis of the illness or **Bodily Injury**, which is neither educational, experimental or investigative in nature nor primarily furnished for the purpose of medical or other research. The **Plan** utilizes the services of the Pacific Foundation for Medical Care to make such determinations utilizing the most current criteria and information available. In any instance the **Plan** reserves the right to seek independent medical Consultant opinions.

"Non-Bargaining Employee" means any full-time, permanent, salaried **Employee** who works an average of 30 hours or more a week in the electrical contracting business for a **Contributing Employer** and who is not covered by a collective bargaining agreement with the **Union** or with any other union.

"**Occupational therapy**" means therapy to treat weakness and/or dysfunction of the body through physical exercise, work related skills and assistive devices.

"**Out-patient**" means a **Covered Person** receiving services, supplies or treatment under the direction if a **Physician** for care of illness or **Bodily Injury** who is not admitted into a **Hospital** or **Skilled Nursing Facility**.

"**Out-patient Surgi-Center**" means either a free-standing institution that is accredited by the Joint Commission on Accreditation of Hospitals, an out-patient facility operated as a part of a **Hospital** or a facility which has been approved by the **Plan**.

"**Physician**" means a licensed Doctor of Medicine or Doctor of Osteopathy. To the extent that benefits are provided, and while practicing within the scope of his license, **Physician** will include a Dentist, Podiatrist, Chiropractor, Acupuncturist, Audiologist, Optometrist or Psychiatrist. **Physician** will not include the **Covered Person's Dependents** or any person who is the **Spouse**, parent, **Child**, brother or sister of a **Covered Person**.

"**Plan**" means the Plan Document of the San Diego Electrical Health and Welfare Trust as administered by the **Board of Trustees**.

"Plan A" means the benefits designed for all **Bargaining** and **Non-Bargaining Employees**, other than **Retirees** covered under **Plan C**, their **Covered Dependents** and/or beneficiaries who are eligible to receive benefits.

"Plan B" means the benefits designed for all **Bargaining** and **Non-Bargaining Employees**, other than **Retirees** covered under **Plan C**, and their properly enrolled **Covered Dependents** and/or beneficiaries who are eligible to receive benefits.

"**Plan C**" means the benefits designed for **Retirees**, their **Covered Dependents** and/or beneficiaries who are eligible to elect to maintain coverage and who are eligible to receive benefits from the San Diego Electrical Pension Trust.

"**Plan Year**" means the calendar year from January 1st through December 31st.

"**Pre-existing Condition**" means: any physical or mental condition for which the **Covered Person** sought care, medical advice, treatment or diagnosis during the six (6) calendar months immediately preceding his/her effective date of coverage.

However, genetic information will not be recognized as a pre-existing condition; nor will a pre-existing condition apply to pregnancy or to children who are newly born, newly adopted or placed for adoption, prior to attainment age 18, on or after the **Covered Employee's** effective date of coverage.

In conjunction with the definition of a **Pre-existing Condition** and the Plan's compliance with **HIPAA** the following definitions will be applicable:

"**Creditable Coverage**" means medical coverage under a group health plan; including governmental/church plans, a hospital or medical service plan contract or HMO (group or individual), Medicare (Part A or B), Medicaid or Medi-Cal (except for pediatric vaccines), military-sponsored health care and certain other government sponsored health plans specified in **HIPAA**.

"**Enrollment Date**" means the first day a **Covered Person** is covered under the Plan.

"HIPAA" means the Health Insurance Portability Accountability Act of 1996.

"Significant Break in Creditable Coverage" means a period of 63 or more consecutive days during which a newly **Covered Person** did not have any Creditable Coverage.

The **Pre-existing Condition** exclusion will not be applicable to any **Covered Employee**, and all **Covered Dependents** who were covered as of the date of his **Loss of Coverage**, who satisfies the requirement for re-qualification of coverage in accordance with Article V. of the Rules of Eligibility for **Bargaining Employees** within 6 months from the date of his **Loss of Coverage**. This exclusion will be applicable to any **Dependent** to be covered under the Plan for the first time, as well as to all **Covered Persons** if the **Bargaining Employee** satisfies the re-qualification requirements after 6 months from the date of his **Loss of Coverage**. However, this exclusion will not be applicable to any Covered Dependent under the age of 19 at the time their coverage becomes effective.

In the event a **Bargaining Employee**, who became **Disabled** and subsequently sustained a **Loss of Coverage**, recovers from his disability and returns to work in covered employment or signs the out-of-work book at the **Union** within 30 days from being released by their **Physician**, then upon his re-qualifying for coverage in accordance with Article V. of the Eligibility Rules for Bargaining Employees under **Plan A** there would be no **pre-existing condition** provision applicable to any newly **Covered Person** who was also a **Covered Person** immediately prior to their **Loss of Coverage.**

Where an interruption in coverage for any **Covered Person** occurs, any pre-existing condition applicable to the **Covered Person's** previous coverage will continue to be excluded from coverage for a period of 12 months from the date coverage subject to this exclusion commenced, regardless of the number of times coverage may be reinstated within the same 12 month period.

"**Pregnancy**" means (1) all pregnancies, (2) childbirth, (3) miscarriage, (4) any **pregnancy** complications arising wholly from these conditions, or (5) any pregnancy complications arising from any trauma.

"**Provider**" means a Doctor or **Physician**, **Hospital**, Licensed Clinic or Medical Facility, **Out-patient Surgi-Center** or **Skilled Nursing Facility** which has provided services and/or supplies to a **Covered Person**.

"**Psychiatric Conditions**" means those conditions, including drug or alcohol dependence, listed in the International Classification of Diseases as diagnostic codes 290-319, and/or a diagnosis which is listed in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, and as may be updated at a later date.

"**Relative Value Studies (RVS)**" means the 1995 Edition of the California Relative Value Studies **(RVS)**, or as modified and adopted by the **Plan**.

"**Retiree**" means any former **Covered Employee** who is or may have been eligible to participate under **Plan C** of this **Plan**.

"**Skilled Nursing Facility**" means a facility that is classified as such under Title XVIII of the Social Security Act (Medicare) and has a transfer agreement in effect with a **Hospital** under Medicare.

"Skilled Nursing Services" means services which require the training and expertise of a licensed Registered Nurse (R.N.), are provided by an R.N. or under the supervision of an R.N. and are in accordance with the **Physician's** order for care.

"**Total Disability**" or "**Totally Disabled**" means that a **Covered Person** is disabled as determined by the Social Security Administration.

"**Trust**" means the San Diego Electrical Health and Welfare Trust.

"Trust Medical Benefits" means the medical benefits available to covered **Plan A** participants which are provided pursuant to an arrangement with a Preferred Provider Organization.

"**Trustees**" or **"Board of Trustees"** means the Board of Trustees of the San Diego Electrical Health and Welfare Trust.

"**Union**" means the LOCAL UNION NO. 569, INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS, AFL-CIO.

"**Urgent or Emergency Admission**" means an unscheduled or unplanned **Hospital** admission required due to the sudden and unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in permanently placing the **Covered Person's** health in jeopardy, causing other serious medical consequences, causing serious impairment to bodily functions or causing serious and permanent dysfunction of any bodily organ or part. The term "immediate" in this definition means a period of not more than twenty-four (24) hours from the onset of the condition which requires the **Covered Person** to be admitted into a **Hospital**.

Usual, Customary and Reasonable" (UCR) means the least of the Usual, Customary or Reasonable fee or charge as defined below:

"**Usual**" means the usual fee or charge that is ordinarily charged for a given service by an individual or **Provider** to his private patient;

"**Customary**" means the customary fee or charge that is made by the **Provider** for a like service or supply but not more than the general level of fees or charges made by other **Providers** within the geographic area (socio-economic area of a metropolitan area or socio-economic area of a county) in which the service or supply is actually provided for **Bodily Injury** or illness of comparable severity and nature. "Area" means a county or such greater area as is necessary to obtain a representative cross-section of **Providers** of the service or supply; or

"**Reasonable**" means the fee or charge of the **Provider** is justifiable in considering all circumstances of the particular case in question.

GENERAL PROVISIONS

Assignment--Benefit payments under this **Plan** may be assignable by any **Covered Person** to a **Provider** of any **Eligible Expense**. All benefit payments for such services rendered by **Providers** of Blue Cross of California Prudent Buyer Plan (a Preferred Provider Organization) shall automatically be payable to the **Provider** pursuant to the Agreement with the **Trust**. Any assignment must be in writing and must be received by the Trust Office prior to the making of any benefit payments to the **Covered Person**. The **Trustees** do not assume responsibility for the validity or sufficiency of any such assignment, and do not assume liability to either the **Covered Person** or the **Provider** to make benefit payments in accordance with such assignment to the **Provider** rather than to the **Covered Person**.

Any **Provider** claiming a right to receive benefit payments pursuant to an assignment shall be limited to the rights and remedies available to the **Covered Employee** under this **Plan**. Any **Provider** who disputes either the denial of an assignment or the amount of benefit payments made under the assignment must exhaust the Claim Review Procedures provisions of the **Plan**.

Beneficiary--Each **Covered Employee** may designate any person desired as their beneficiary to receive life insurance and accidental death benefits. To be valid, said designation must be on the prescribed enrollment card as prepared by the **Trustees**, executed by the **Covered Employee** under penalty of perjury, and filed with the Trust Office. If the **Covered Employee** is married, and the designated beneficiary is any person other than his **Covered Spouse**, the **Covered Spouse** must consent in writing in order for the designation to be valid. Further, in the event a **Covered Employee** fails to designate a beneficiary, or the designation is invalid for any reason, any and all benefits payable will be paid in accordance with the laws of succession of the State of California.

Change of Beneficiary--The **Covered Employee** may change the designation of beneficiary at any time by filing a new enrollment card with the Trust Office. The consent of the beneficiary or beneficiaries is not required except when the **Covered Employee** is married and the designated beneficiary is other than his **Covered Spouse**, in which case the consent of his **Covered Spouse** will be necessary in order for the designation to be valid.

Changes--No changes in this **Plan** shall be valid unless approved by the **Trustees**, and no agent or employee of the **Trust**, of the **Union**, of the **Employer Association** or any **Contributing Employer** has any authority to change this **Plan** or to waive any of its provisions or requirements. The **Trustees** shall have the sole discretion to amend and change this **Plan** at any time, without the consent of any **Covered Person**, by action duly noted in the minutes of a meeting of the **Trustees** or by a written Amendment to the provisions of this **Plan**; provided that no such change or Amendment shall be made which shall prejudice any claim arising prior to the date of such change.

Claim Procedures--This Section shall apply to each coverage under this **Plan** which does not contain a specific contractual provision relating to the payment of benefits.

A. Proof of Loss--Written proof of claim must be furnished to the **Plan** within one year of the date the claim was incurred, except in the absence of legal capacity of the **Covered Person**. Failure to provide such notice will invalidate any claim unless it shall be proven to the satisfaction of the **Trustees** that it was not reasonably possible to furnish such notice or proof within the time limits provided. In the event of services rendered outside of the United States (U.S.) any and all proofs of claim must be submitted in, or translated to, the English language and be valued in U.S. currency. Otherwise the claim will not be valid and the **Trust** shall have no liability for payment.

B. Review of Claims--All proofs of claim shall be processed in accordance with the administrative guidelines established by the **Trust**, or by the peer review committee of the Pacific Foundation for Medical Care, for determining whether a particular claim qualifies as an **Eligible Expense** and that the amount paid was the appropriate **Allowable Charge** under any provision of this **Plan**. These administrative guidelines, which are incorporated herein by reference as though set forth in full, shall control the interpretation as to whether a particular claim is in fact an **Eligible Expense** unless the same are clearly inconsistent with the terms of this **Plan**.

C. Payment of Benefits--All benefit payments to be made shall be paid to or for the benefit of the **Covered Person** as they accrue. Subject to any written direction of the **Covered Person** in an application or otherwise, all or

any portion of the benefit payments provided by the **Plan** may be paid directly to the **Hospital** or **Provider** rendering such services. Any benefits unpaid at the **Covered Person's** death may, at the option of the **Plan**, be paid to the **Covered Person's** estate.

D. Physical Examination and Autopsy--The **Plan**, at its own expense, shall have the right and opportunity to examine the person of any individual whose injury or illness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

E. Failure to Provide Requested Information – In the event the **Plan** determines that a **Covered Person** has not responded to multiple requests to provide information or documentation deemed necessary to permit processing of a pending claim and/or to verify **a Covered Person's** eligibility, the **Plan** shall have the right to deny the pending claim(s).

Clerical Error--Clerical Error by the **Trust** shall not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Coordination of Benefits--All self-funded medical benefits provided under the **Trust Medical Benefits** are subject to the following provisions and limitations.

A. Definitions (for Coordination of Benefits Section only)

(1) Group Plans--The term "Group Plan" means any of the following plans which provide benefits or services for or by reason of medical care or treatment:

(a) Blanket Group Coverage. Blanket Group Coverage includes all group or group subscriber contracts as well as group-type contracts, which are not available to the general public and can be obtained and maintained only because of the **Covered Person's** membership in or connection with a particular group or organization;

(b) Governmental Programs. Governmental Programs include any coverage required or provided by any statute including, but not limited to, Champus, Champ VA and Part A and Part B of Medicare;

(c) Prepaid Plans. Prepaid Plans include coverage provided under a hospital or medical service plan, Health Maintenance Organization or other prepayment coverage provided on a group basis; or

(d) Employee Benefit Plans. Employee Benefit Plans include any group labor-management trusteed plan, union plan, group association plan, employer organization plan or employee benefit organization plan.

(2) Private Plans--The term "Private Plans" means any individual liability policy or contract required by law to the extent there is any form of medical expense benefits paid or payable, irrespective of whether such coverage was in effect at the time of loss.

(3) Automobile, Craft or Vehicle Insurance--In many States owners of private motor vehicles or crafts are required to obtain automobile insurance or "No-Fault" automobile insurance covering their vehicles. Benefits payable under this **Plan** will be secondary to any medical expense benefits which a **Covered Person** has, or could have, received from their insurance and/or personal injury protection coverages as may be required by law, without regard to any deductible which may be in effect and without regard to the purchase of such insurance by, or on behalf of, the **Covered Person**. Accordingly, if a **Covered Person** fails, for any reason whatsoever, to obtain and maintain the minimum amount of insurance as required by law, or if a deductible is included under such insurance coverage, the **Plan** shall pay benefits as if the **Covered Person** had such insurance coverage in effect at the time of loss with no deductible.

(4) Student Accident Insurance -- The term "Student Accident Insurance" refers to any individual or group insurance policy covering a **Dependent Child** for an accident, injury or an event requiring immediate and/or future medical services. With respect to a **Dependent Child's** participation in sporting events this term will recognize their participating in, practicing for, and/or traveling to/from any organized individual or team sporting event while representing an educational institution and/or to any individual

or group insurance policy covering a **Dependent Child** participating in an All-Star or traveling sports team that may not be representative of, or sponsored by, an educational institution.

Further, if an insurance policy covering an automobile or any other craft or vehicle, including air or water craft, or a Student Accident insurance policy, provides that coverage for medical expense benefits is applicable on an "excess" basis only then there would be no benefits payable by this **Plan** until such time as the maximum amount of medical expense benefits payable under said policy have been paid.

B. Effect on Benefits. This provision shall apply in determining the benefits due a person covered under this **Plan** for any **Plan Year** if the sum of the benefits that would be payable under this **Plan**, in the absence of Coordination of Benefits, and the benefits that would normally be payable under all other plans and/or automobile, craft, ~~or~~ vehicle or a Student Accident insurance policy would exceed 100% of the **Eligible Expenses** actually incurred.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an **Eligible Expense** and a benefit paid.

This **Plan** shall not be required to determine the existence of any other plan or automobile, craft or vehicle insurance policy(ies), or the amount of benefits payable under any plan or automobile, craft or vehicle insurance policy(ies) other than this **Plan**. The payment of benefits under this **Plan** shall be affected by the benefits payable under other plans or automobile, craft, ~~or~~ vehicle or a Student Accident insurance policy. The **Covered Person** must furnish this **Plan** with information concerning the existence of such other plan(s) or automobile, craft, ~~or~~ vehicle or a Student Accident insurance policy by the Employer, any insurance company, organization or **Covered Person**.

(1) As to any **Plan Year** to which this provision is applicable, the benefits that would be payable under this **Plan**, in the absence of Coordination of Benefits, for **Eligible Expenses** shall be reduced to the extent necessary so that the sum of (a) such reduced benefits and (b) all the benefits paid or payable for such **Eligible Expenses** under all other Group Plans, Private Plans and/or automobile, craft, ~~or~~ vehicle or a Student Accident insurance policy shall not exceed the total of such **Eligible Expenses**.

In the event a **Covered Spouse** is in any way entitled to group medical-hospital benefits through their employer or another group affiliation, which would have been their primary source of coverage if said coverage was in effect at the time **Covered Expense** was incurred, if the **Covered Spouse** voluntarily declined or waived such coverage that was available to them free of charge or if they receive any form of compensation in return for waiving such coverage then there will be no medical-hospital benefits coverage under this **Plan** for any **Eligible Expenses** related to the claim(s) incurred by the **Covered Spouse** that would have otherwise been the primary responsibility of the group coverage that was declined or waived. This exclusion shall also apply to all **Covered Dependent Children** if they would have been included under the **Spouse's** medical-hospital benefits coverage on a primary basis at no additional cost to the **Spouse**.

Further, in an instance where the **Plan** will not provide group medical-hospital benefits to a **Covered Spouse** or **Dependent Child** due to the above provision they will continue to be eligible for dental, vision, MAP and supplemental life insurance benefits otherwise available under the **Plan** to a **Covered Dependent**.

(2) If another Group Plan, Private Plan and/or automobile, craft or vehicle insurance policy insuring or covering the person under this **Plan** contains a non-duplication of medical expense benefits provision which coordinates its benefits with those of this **Plan**, and would determine its benefits after the benefits of this **Plan** have been determined, then the benefits of such other Group Plan, Private Plan and/or automobile, craft, vehicle or a Student Accident insurance policy will be considered for the purposes of determining the benefits due under this **Plan**.

(3) For the purposes of this Section, the rules establishing the order of benefit determination are: (1) The benefits of a Group Plan which covers the **Covered Person** on whose expense claim is based other than as a dependent, shall be determined before the benefits of a Group Plan which covers such **Covered Person** as a dependent; (2) For **Covered Children's** expenses where both the mother and father have dependent coverage then the Group Plan of the parent who's birthday falls earlier in the calendar year is primary. For **Covered Children** where the parents are separated or divorced, if there is a court decree that establishes responsibility for medical coverages then that would determine which Group Plan is

primary. Otherwise, the Group Plan covering the parent with custody of the **Covered Children** would be primary. If the parent with custody remarries and the **Covered Children** are covered under the Group Plan of the parent with custody or the step-parent then the Group Plan covering the parent would be primary and that of the step-parent would be secondary. If the **Covered Children** are also covered by the parent who does not have custody, then that Group Plan would be in the third position; (3) Where an **Employee** is simultaneously covered under more than one Group Plan the Group Plan that covers the person as an active employee (or as their dependant) will be the primary plan to a Group Plan that previously covered the employee (or their dependent). This provision will also apply in an instance where the person (or their dependant) remains covered under a former Group Plan in accordance with COBRA Continuation Coverage. (4) When rules (1), (2) and (3) do not clearly establish an order of benefit determination, the benefits of a Group Plan which has covered the person on whose expense claim is based for the longer period of time shall be determined first. Neither a change in the amount or scope of benefits provided by a Group Plan, a change in the carrier insuring or the sponsor of the Group Plan, nor a change from one type of plan to another, would constitute the start of a new Group Plan for purposes of this Section.

C. Primary Plan. If any Group Plan lacks a Coordination of Benefits provision or fails to recognize the "Coordination of Benefits Birthday Rules", it is the primary plan, while if both parents are **Covered Employees** primary coverage on behalf of the **Children** will be determined in accordance with the "Birthday Rules" under Coordination of Benefits. However, each family member will be entitled to coverage not to exceed the maximum amounts stated in the Schedule of Benefits and/or under **Eligible Expenses**.

D. Prepaid Plans. In the event a **Covered Person** has primary coverage through a Health Maintenance Organization (HMO) or any other type of Prepaid Health Plan, such **Covered Person** shall be subject to the Coordination of Benefits provisions of this **Plan**. The HMO or other Prepaid Health Plan will be considered primarily responsible to provide coverage. In such instances the **Covered Person** must utilize the HMO's or Prepaid Health Plan's facilities, **Physicians** and/or services and benefits will be payable under this **Plan** only if a **Covered Person** requires services not covered by or not obtainable from the HMO or other Prepaid Health Plan. Where a Prepaid Plan provides benefits in the form of services, rather than cash payments, the reasonable cash value of each service rendered shall be considered as both an **Eligible Expense** and Benefit paid.

Where this **Plan** is in a secondary capacity and a co-payment is required toward the cost of any service(s) under a Prepaid Plan, other than Mental Health/Substance Abuse, this **Plan** will only be responsible for reimbursing the **Covered Person** for the amount of such co-payments at 100% without application of a deductible. In that all Mental Health/Substance Abuse benefits under this **Plan** are provided exclusively through contractual arrangements with the Members' Assistance Program and MHN under no circumstances will such treatment rendered by any other **Provider(s)** be considered as eligible for reimbursement under this provision.

E. Facility of Payment. Whenever payments which should have been made under this Group Plan are made under any other plan, this **Plan** shall have the right in its sole discretion to pay to any organization making such payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this **Plan** and, to the extent of such payments, this **Plan** shall be fully discharged from liability.

Cost of Coverage--The cost of coverage under this **Plan** shall be made either in the form of a charge of hours against a **Covered Employee's** Reserve Account and/or by the requirement that a **Covered Employee** make **Direct Payments** as permitted herein.

The cost of coverage shall be determined by the **Trustees** based upon actuarial projections of the cost of providing benefits to all **Covered Persons** under each of the combinations of benefits offered by this **Trust**, and upon whether coverage of a particular benefit plan is provided under a Comprehensive Medical Plan or one of the HMO Plans and if supplemental life insurance will be applicable.

The **Trustees** shall have the sole authority and discretion to establish and change at any time the cost of coverage required for continued eligibility; provided, that no change in the cost of coverage will operate retroactively to terminate the eligibility of any **Covered Person** or prospectively to terminate the coverage of any **Covered Person** without reasonable notice of the adoption of any such change in cost of coverage.

Invalidity of Certain Provisions Does Not Invalidate All--If any provisions of this **Plan** shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision hereof and this **Plan** shall be construed and enforced as if such provisions had not been included.

Legal Actions--No action at law or in equity may be brought by any **Covered Person** or **Provider** to recover against this **Plan** unless the **Covered Person** or **Provider** has first exhausted the Claim Review Procedures of this **Plan**.

Medical Records--The **Trust** shall be entitled to keep and maintain medical records of service(s) provided to all **Covered Persons** in such form and for such duration as the **Trustees** direct.

A. Liability for Information. The **Trust** shall have no responsibility or liability to any **Covered Person** or any third party for any incorrect or incomplete information provided to the **Plan** and/or contained in the records of this **Plan**, or for any act or omission of any **Covered Person** or any third party caused by any such inaccurate or incomplete information.

B. Release of Information. The **Trust** may only release to, or obtain from, any insurance company, **Provider** or other organization or person any information with respect to any **Covered Person** which the **Trust** deems to be reasonable or necessary to evaluate any claim and to carry-out the purpose of this **Plan** in accordance with the Privacy Rules established under **HIPAA of 1996** and as may be amended .

C. Furnishing Information. Any **Covered Person** claiming benefits under this **Plan** shall furnish to this **Trust** such information as may be necessary to substantiate or evaluate any claim for benefits or to implement this Section. Failure to furnish such information shall be sufficient grounds for the **Trustees** to deny any such claim.

Pronouns--Masculine Pronouns used herein shall apply to both sexes.

Right of Recovery--The right to receive benefits under this **Plan** is limited solely to the **Eligible Expenses** covered by this **Plan** as qualified by the Coordination of Benefits provisions. The **Trust** shall have the right to recover the amount of any and all excess benefits paid to or on behalf of a **Covered Person** or paid to any **Provider**; the right to recover the amount of any benefits paid in error or paid because the information contained in a proof of claim is misrepresented or erroneously presented by either the **Covered Person** or the **Provider**; and the right to recover the amount of all benefits paid to or on behalf of a person who is no longer eligible to receive such benefits.

A. Remedies Available. Liability to the **Trust** is joint and several. The **Plan** shall have the right to recover any excess payments directly from either the **Covered Person** and/or the **Provider**. The **Plan** shall also have the right to recover any excess payments, and to satisfy this obligation by withholding all future benefit payments, on behalf of each of the following persons:

(1) The **Covered Person**;
(2) The **Covered Employee** or **Covered Retiree**, if the **Covered Person** is a **Covered Dependent**; or,
(3) Any **Covered Dependent**, if the **Covered Person** is a **Covered Employee** or **Covered Retiree**.

B. Notice of Claim. The **Trustees** shall send written notice to the **Covered Person**, and to the **Covered Employee** or **Covered Retiree** if the **Covered Person** is a **Covered Dependent**, of the determination of the amount of any excess payments and the reason(s) for such determination. The **Trustees** shall also send written notice to the **Provider** where applicable. If either the **Covered Employee**, **Covered Retiree** or **Covered Dependents** disagree with that determination an appeal may be filed in accordance with the Claim Review Procedures.

C. Enforcement. If no appeal is filed, the decision of the **Trustees** will become final and binding and may be enforced as an arbitration award pursuant to California Code of Civil Procedure, Title 9, Chapter 4, Sections 1285, et seq.

D. Damages. In any action brought by the **Plan** to enforce an award the **Trust** shall be entitled, as a part of any recovery under this Section, to recover the full amount of all peer review expenses, medical investigation charges, auditors' fees incurred and to reasonable attorney's fees and costs pursuant to Section 502(g)(1) of **ERISA** and the terms of this **Plan**.

Standards of Proof--The **Trustees** shall be the sole judge of the standards of proof required in any case and shall have the full and exclusive power and authority, in their sole discretion, to determine all questions of coverage and eligibility for benefits, methods of providing or arranging for benefits and all other related matters. The **Trustees** shall have the full power and authority, in their sole discretion, to construe and interpret the provisions and terms of this Plan Document and all other written Documents, and any such construction and interpretation adopted by the **Trustees** in good faith shall be binding upon all **Covered Persons**, all **Providers**, all **Contributing Employers**, the **Union** and all other persons.

Termination of the Plan--The **Plan** may be terminated at any time by action of the **Trustees**. Notice of such termination shall be given in writing to the United States Department of Labor and to all persons who have an interest in the **Plan**. All claims which have not been submitted at the date of termination, but which would have been paid had the **Plan** continued, will be paid in accordance with all of the provisions of the **Plan** at the time of termination, except that there is no liability to the **Trustees** or any **Covered Person**, any **Contributing Employer**, the **Union** or any individual or entity to provide payments over and beyond the amounts available in the **Trust** for such purposes.

Third Party Claims--If a **Covered Person** receives benefits from this **Trust** for **Bodily Injuries** or illnesses sustained from the acts or omissions of any third party, the **Trust** shall have the right to be reimbursed in the event the **Covered Person** recovers all or any portion of the benefits paid by the **Trust** by legal action, settlement, or otherwise, regardless of whether such benefits were paid by this **Trust** prior to or after the date of any such recovery. The **Covered Person** will not be entitled to receive any benefits for such expenses under this **Trust** unless he executes a Subrogation Agreement agrees in writing to the following conditions:

A. Reimbursement to Trust. To authorize reimbursement to the **Trust** to the extent of all benefits paid by this **Trust** as a result of such injuries immediately upon obtaining any monetary recovery from any party or organization whether by action at law, settlement or otherwise by virtue of executing a Subrogation Agreement, with the understanding that any and all monies recovered from any third party are to be deposited in an exclusive bank account to be established in joint name including the **Trust** and to contain only these monies. No monies shall be withdrawn from such account without express written acknowledgment and authorization from this Plan's Administrator. Any payment received by the participant or the participant's eligible dependents is subject to a constructive trust. Any third-party payment received by the participant or the participant's eligible dependents must be used first to provide restitution to this Plan to the full extent of the benefits paid or payable under this Plan.

   (1) This Plan does not recognize the Make-Whole Doctrine. This Plan is entitled to obtain restitution of any amounts owed to it either from third-party funds received by the participant or the participant's eligible dependents, regardless of whether the participant or the participant's eligible dependents have been made whole for losses sustained at the hands of the third party.

   (2) This Plan expressly rejects the Common Fund Doctrine with respect to payment of attorney's fees. A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise this Plan's equitable (or other) right to obtain full restitution.

B. Assignment of Rights. To irrevocably assign to the **Trust** all rights to recover monetary compensation from the third party to the extent of all benefits paid by this **Plan** and to give notice of this assignment directly to such third parties, their agents or insurance carriers, or to any agent or attorney who may represent the **Covered Person**. The assignment shall entitle the **Trust** to reimbursement from any sums to be held or received by the following third parties which are due to the **Covered Person** prior to any distribution of funds to the **Covered Person**, and shall provide that such parties shall specifically direct that any and all monies recovered from any third party are to be deposited in an exclusive bank account to be established in joint name including the **Trust** and to contain only those monies for the benefit of the **Trust**. No monies shall be withdrawn from that account without the knowledge and expressed approval of the **Trust**. The parties who shall be bound by such assignment are:

   (1) Any party or its insurance carriers making payments to or on behalf of the **Covered Person**; or,
   (2) Any agent or attorney receiving payments for or on behalf of the **Covered Person**.

C. Notice. To notify the **Trust** of any claim or legal action asserted against any third party or any insurance carrier(s) for such injuries or illnesses, as well as the name and address of such third parties, insurance carrier(s), any agent or attorney who is representing or acting on behalf of the **Covered Person** or the estate of the **Covered Person**, or any person claiming a right through such **Covered Person**, on a form to be supplied by the **Trust**.

D. Proration of Reimbursement. If the "net recovery" received by the **Covered Person** from all sources, whether from more than one tortfeasor, under any Worker's Compensation law or otherwise is less than two times the amount of the benefits paid by this **Plan** the **Trust** has the right to be repaid from the net recovery received by the **Covered Person** from any party or its insurance carrier according to the following schedule as full settlement for all benefits paid by this **Trust**:

Percentage of Subrogation	**Net Recovery v. Trust Payment**
100%	2 times or more
75%	1½ times or more
66⅔%	Equal or more
50%	½ or more
33⅓%	Less than ½

For the purpose of this Section "net recovery" means the actual amount to be received by the **Covered Person** after deducting all attorney fees and costs.

E. Subrogation. The **Plan** shall have the independent right to bring suit in the name of the **Covered Person**. The **Plan** shall also have the right to intervene in any action brought by the **Covered Person** against any third party, to and including the insurance carrier of the **Covered Person** under any uninsured or under-insured motorist provision or policy. The **Covered Person** further agrees to take no action inconsistent with the requirements of this provision.

F. Cooperation With Trust. The **Covered Person**, as well as their attorney or agent shall cooperate fully with the **Trustees** in the exercise of any Assignment or right of Subrogation, and not to take any action or refuse to take any action which would prejudice the rights of the **Trust**.

G. Withholding Future Benefits. To acknowledge that this **Trust** shall have the Right of Recovery against the **Covered Person**, should the **Covered Person** and/or their legal representative fail to execute an Assignment, Subrogation Agreement or any other documents required herein, the Trust may withhold future benefit payments to be made on behalf of the **Covered Employee** or any of their **Covered Dependents** until such time as the Trust is fully protected as provided for in this Section.

H. Disclaimer. If there is any reasonable cause to believe that the injuries or illnesses sustained by a **Covered Person** were in any way the result of the acts or omissions of a third party or parties, but the **Covered Person** disclaims any third party involvement, the **Trust** shall have the right to require the **Covered Person** (or the **Covered Dependent** if the **Covered Person** is a **Dependent**) to sign a declaration, under penalty of perjury, regarding such disclaimer as a pre-condition to the payment of any benefits.

I. Separate Rights. Each of the provisions set forth about relating to the right of this **Trust** to receive reimbursement for **Eligible Expenses** paid to or on behalf of a **Covered Person** because of injuries sustained relating to or resulting from the acts and omissions of any third party is separate and any illegality or invalidity of any one provision shall not affect the legality or validity of any other provision.

J. Medical Expenses Incurred After Settlement or Final Judgment in Third Party Claim. In the event a **Covered Person** incurs medical expenses relating to his or her injuries or disabilities which are the subject of a Subrogation Agreement following any settlement or final judgment received from the third party (ies) responsible for the injuries, the **Plan** shall have no further responsibility to pay for such medical expenses. The **Covered Person** shall agree to release and hold the Trust harmless from any further obligations under the Subrogation Agreement for any future medical expenses incurred following any settlement or final judgment received from the third party(ies) responsible for the injuries. However, provisions can be made by the **Covered Person** for the continued payment of such medical expenses by the third party(ies) pursuant to a settlement agreement which is approved by the Trust in writing prior to the execution thereof. In that event, the rights of the **Covered Person** to the continued payment of medical expenses shall also be assigned to the Trust under the Subrogation Agreement and the **Covered Person** shall be required to reimburse the Trust for 100% of all medical expenses paid by the Trust under this provision following execution and payment by the responsible third party(ies) under the settlement agreement or final judgment.

K. Acknowledgment by Agent or Attorney. To acknowledge that the **Covered Person**'s claim for benefits under the Trust will not be processed or paid by the **Trust** until the Trust Office receives a duly executed acknowledgment of the terms of the required Subrogation Agreement from the agent or the attorney of the **Covered Person** in the form and content acceptable to the **Trust**. The **Covered Person** shall direct that the agent or attorney shall readily comply with the terms of the Subrogation Agreement, with the obligation to deposit any and all monies recovered in the exclusive bank account referenced above, with the obligation that no monies shall be withdrawn from such account without express written acknowledgment and authorization from the **Trust**. Finally, the **Covered Person** shall direct the agent or attorney to reimburse the **Trust** in accordance with the Reimbursement Schedule as outlined above.

L. Medical Bills Received After Settlement. In the event a bill for medical services applicable to the accident is received by the Trust Office after settlement with the **Trust** in accordance with the **Plan's** "Right of Recovery" it will become the **Covered Person's** financial responsibility, in accordance with the reimbursement schedule, to the extent the bill had been remitted on a more timely basis and would have been paid by the Trust prior to settlement, and for which the **Trust** would have been reimbursed for part or all of the amount paid as part of said settlement.

Time Effective--The effective time with respect to any dates used in the **Plan** or any Amendment thereto shall be 12:01 A.M. Standard Time at the address of the **Trustees**.

Worker's Compensation Not Affected--This **Plan** is not in lieu of, and does not affect, any requirement for a **Contributing Employer** to procure and maintain coverage by Worker's Compensation Insurance.

PART THREE

STATEMENT OF EMPLOYEE RIGHTS UNDER ERISA (EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974)

Your Rights

As a participant in the San Diego Electrical Health & Welfare Trust 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 the following.

You can examine, without charge, at the Trust Office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Employee Benefits Security Administration.

You can obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

The plan administrator is required by law to furnish each participant with a copy of the summary of his/her annual financial report.

Continue Group Health Plan Coverage

You can continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

There is a reduction or elimination of exclusionary periods of coverage for preexisting 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, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, 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 schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive it 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 administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

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 costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Trust 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 administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

COBRA CONTINUATION COVERAGE

Since April 7, 1986 Federal law (Public Law 99-272, Title X) requires that most employers sponsoring group health plans offer **Employee**s and their families the opportunity for a temporary extension of health coverage (called **continuation coverage**) at group rates in certain instances where coverage under the **Plan** would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the new law. (Both you and your **Spouse** should take the time to read this notice carefully or refer to the Rules for Continuation Coverage on page 32).

If you are an **Employee** of a **Contributing Employer** covered by the San Diego Electrical Health & Welfare Trust (the "**Plan**"), you have a right to choose this continuation coverage if you suffer a loss of coverage because of a reduction in your hours of employment or the termination of your employment (except if the **Covered Employee** continues in the employ of his **Employer** and his **Employer** is no longer signatory to a Collective Bargaining Agreement or his **Employer** fails to make timely contributions due to this **Plan**).

If you are the **Spouse** of a **Covered Employee** or **Retiree** covered by the **Plan**, you have the right to choose continuation coverage for yourself if you lose your coverage under the **Plan** for any of the following six reasons:

1. the death of your **Spouse**; or
2. the **Covered Employee** suffers a **Loss of Coverage**; or
3. divorce from a **Covered Spouse or Retiree**; or
4. the **Covered Employee** or **Retiree** becomes covered by Medicare benefits; or
5. The termination of a domestic partnership between the **Covered Employee** or **Retiree** and the **Domestic Partner**.

In the case of a **Dependent Child** of an **Employee** covered by the **Plan**, he or she has the right to continuation coverage if coverage under the **Plan** is lost for any of the following reasons:

1. the death of the **Covered Employee** or **Retiree**; or
2. the **Covered Employee** suffers a **Loss of Coverage (**except if the **Covered Employee** continues in the employ of his **Employer** and his **Employer** is no longer signatory to a Collective Bargaining Agreement or his **Employer** fails to make timely contributions due to this **Plan**; or
3. parent's divorce; or
4. the **Covered Employee** or **Retiree** becomes covered by Medicare benefits; or
5. the termination of a domestic partnership between the **Covered Employee** or **Retiree** and the **Domestic Partner**; or
6. the **Dependent** ceases to be a "**Dependent Child**" under the **Plan**.

Under the law, the **Employee** or family member has the responsibility to inform the Trust Office of the **Plan** of a divorce or a **Child** losing dependent status under the **Plan**. The **Plan** will not provide continuation coverage to a **Spouse** or **Child** unless the **Board of Trustees** is notified, in writing, of these changes in status within 60 days after the divorce or **Child** losing dependent status. The **Contributing Employer** for whom the **Employee** is working has the responsibility to notify the Trust Office of the **Employee's** death, termination of employment, or reduction in hours or Medicare Entitlement.

When the Trust Office is notified that one of these events has happened, the Trust Office will in turn notify you that you have the right to choose continuation coverage. Under the law, you have 60 days from the date you would lose coverage because of one of the events described above to inform the Trust Office that you want continuation coverage.

Cost of COBRA

If you elect COBRA continuation coverage, you must pay the cost of such coverage. The COBRA continuation coverage premiums are adjusted annually by the Trust and reflect 102% of the cost of coverage as of the date the premiums are set for the coverage. If you are totally disabled and qualify for the special extension of an additional 11 months of coverage, the premium for the 19th through 29th months of the extended coverage will be 150% of the cost of that coverage and administrative expenses.

Election of COBRA Coverage

You will have at least 60 days in which to elect COBRA continuation coverage. If individuals who have lost coverage and are eligible for COBRA continuation coverage fail to make an election within the 60-day time period, rights to COBRA continuation coverage will be waived.

If you or your spouse or dependent have COBRA continuation coverage through the Plan's HMO program and you are terminated from the program because you move out the Plan's service area before the applicable COBRA period expires and the Plan does not have a contract with your Plan in that area your COBRA coverage will cease.

Your self-payment for COBRA continuation coverage is payable on a monthly basis. It is your responsibility to pay the self-payment directly to the Trust Office in a timely fashion. You must make your first payment within 45 days after the date that COBRA continuation coverage is elected. If you fail to timely pay your COBRA premium, you will immediately lose your coverage.

****If you do not choose continuation coverage, your coverage by the Trust will end.****

If you choose continuation coverage, the **Plan** is required to give you coverage which, as of the time coverage is being provided, is identical to other coverage provided under the **Plan** to similarly situated **Employees** or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost your coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months (or 29 months if you are determined by the Social Security Administration to be **Totally Disabled**. The disability must have started at sometime on or before the 60th day of COBRA continuation coverage). However, the law also provides that your continuation coverage may be cut short for any of the following four reasons:

1. The **Plan** no longer provides group health coverage to any of its **Employees**;

2. The premium for your continuation coverage is not paid on a timely basis;

3. You become covered under another employer sponsored group health plan (as an **Employee** or otherwise) containing no limitation or exclusion as to any **Pre-existing Condition**; or

4. You become entitled to Medicare benefits. For the purpose of this provision a person will be considered "entitled to Medicare" if they attain age 65 and are eligible for Medicare if the person has applied for Social Security benefits or has filed an application for Medicare Part A; or

5. For **Dependents** only - the **Spouse** or **Child** ceases to be a "**Covered Dependent**" and do not timely elect their own Continuation Coverage. Also, upon the death or divorce of the **Covered Employee** after the initial qualifying event, Continuation Coverage shall immediately terminate for a **Covered Dependent** who was not a **Covered Person** before Continuation Coverage first began, or;

6. For disabled persons only - As of the first day of the month following the date the person is no longer **Totally Disabled** as finally determined by the Social Security Administration.

You do not have to show that you are insurable to choose continuation coverage. However, you do have to pay the full cost of your continuation coverage to the extent permitted by the law. [The law also says that at the end of the 18, 29 or 36 month continuation coverage period, you must be allowed to enroll in an individual conversion plan provided by the **Plan**, if such an individual conversion plan is otherwise generally provided by the **Plan**.]

This law applies to the **Plan** at this time. If you have any questions about the law, please contact the Trust Office. Also, if you have changed marital status, if you or your **Spouse** have changed addresses or if your **Child** ceases to be a **Covered Dependent** the **Trust Office must be notified within 60 days of such an occurrence, otherwise the right to elect continuation coverage shall be forfeited.**

A copy of this notice is being sent to you and your family, by first class mail, at your address on file with the Trust Office. If your **Spouse** or any other **Dependent** does not reside with you, please notify the Trust Office.

San Diego Electrical Health & Welfare Trust
P.O. Box 231219
San Diego, CA 92193-1219
Telephone: (858) 569-6322 or (800) 632-2569 if outside the (858) area code.
Extension #310

QUALIFIED MEDICAL CHILD SUPPORT ORDER

In August, 1993, a federal law went into effect which requires all **Employee** benefit plans to recognize Qualified Medical Child Support Orders for the purpose of providing health coverage to **Dependents** of a **Covered Employee** or **Retired Employee** in connection with the **Covered Employee** or **Retired Employee's** separation or divorce from his or her **Spouse**. In order for this **Plan** to recognize a Qualified Medical Child Support Order, it must satisfy the following criteria:

1. It must be a judgement, decree or other court order relating to health benefits coverage for a **Dependent Child** of a **Covered Employee** or **Covered Retired Employee**; and,

2. The order must specify:
   a. the name and address of the **Employee** or **Retired Employee**;
   b. the name and mailing address of each **Dependent Child** covered by the order;
   c. a reasonable description of the type of coverage afforded by the **Plan**;
   d. the beginning period for which the order applies; and
   e. the name and address of each Alternate Payee, which means the **Spouse**, former **Spouse**, legal guardian of the **Dependent Child** or the **Child** of an **Employee** or **Retired Employee.**

Upon receipt of a medical child support order, the Administrative Manager shall promptly notify the **Employee** or **Retired Employee** and Alternate Payee. The **Trustees** shall determine whether an order received meets the criteria and promptly notify the **Employee** and each Alternate Payee. In the event of a dispute regarding any medical child support order furnished to the **Trust**, the **Employee** or Alternate Payee shall promptly notify the Trust Office in writing.

Coverage shall commence upon either the date specified in the order or the date the **Employee** or **Retired Employee** becomes eligible for coverage, if later.

Any order which requires this **Plan** to provide any type of benefit or increased benefits not otherwise provided by this **Plan** or coverage for any period of time the **Employee** or **Retired Employee** is not covered under this **Plan**, other than under COBRA, will not be recognized as a Qualified Medical Child Support Order.

FAMILY AND MEDICAL LEAVE ACT

On February 5, 1994, a federal law was enacted known as the Family and Medical Leave Act which provides that **Employers** who employ fifty or more persons within a seventy-five mile radius of the worksite are required to maintain health coverage for their **Employees** under certain circumstances. If you have been employed for such an **Employer** for a minimum of twelve months, and have worked at least 1250 hours over the last twelve month period, you may be entitled to continued health coverage under this **Plan** for up to twelve weeks during any twelve month period for one or more of the following events:

1. the birth of a **Child** of an **Employee**;
2. adoption of a **Child** by an **Employee** or placement of a **Child** in the foster care of an **Employee**;
3. serious illness of an **Employee**, **Child**, **Spouse** or parent of an **Employee;** or
4. Due to any qualifying exigency (as the Secretary of the Department of Labor shall determine by regulations) arising out of the fact that your **Spouse**, **Child** or parent is on active duty in the **Armed Forces** in support of a contingency operation.

It shall be the responsibility of an **Employee's Employer** to maintain contributions to the **Trust** on behalf of the **Employee** for the **Employee's** health coverage to continue while the **Employee** is on leave. It shall be the responsibility of the **Employee** to notify the Trust Office that leave is taken under the Family and Medical Leave Act, as well as the commencement date of such leave and the duration. If the **Employee** is entitled to continued health coverage under the Family and Medical Leave Act, so long as required monthly contributions are received by the **Plan** from the **Employee's Employer** the **Plan** is required to provide coverage which, as of the time coverage is provided, is identical to the coverage provided to the **Employee** at the same level and under the same conditions as coverage would have been provided if the **Employee** were still working. COBRA Continuation Coverage is available if the **Employee** does not return to work after an approved leave under the Family Medical Leave Act. Upon an **Employee's** return to employment after leave under the Family and Medical Leave Act, even if coverage was not maintained while the **Employee** was on leave, an **Employee** will not be subject to a new **Pre-existing Condition** waiting period or medical exam before reinstatement. COBRA Continuation Coverage is available if the **Employee** does not return to work after an approved leave under the Family Medical Leave Act.

It is not the role of the **Trustees** or the **Trust** to determine whether or not an individual **Employee** is entitled to FMLA benefits. Disputes as to the entitlement to FMLA benefits must be resolved by the **Employee**, **Employer** and, where applicable, the **Union**.

If you have any questions about the Family and Medical Leave Act, please contact the Trust Office.

MILITARY SERVICE
(Uniformed Services Employment and Re-employment Rights Act of 1994)

A Covered Employee should notify the Trust Office upon their preparing to report for active duty or military training. When a **Covered Employee** enters the military service for active duty or military training under the laws of the United States coverage under the Health and Welfare **Plan** for themself and their eligible **Dependents**, if applicable, will be terminated upon their becoming covered by the U. S. Government (usually after 30 days of service) and his **Reserve account** will then be frozen awaiting possible future reinstatement upon their return to work in covered employment on a timely basis.

Upon being released or discharged from military service or training, said **Employee** shall, within ninety (90) days thereafter, apply to the Trust Office for reinstatement of any reserve account hours that were in existence upon their becoming eligible for health insurance through the U. S. Government. This clause does not apply to military duty when such duty does not exceed 30 days a year. However, if the **Covered Employee** does not notify the Trust Office in advance of their entry into the military, and coverage under the **Plan** continues through use of their existing reserve account hours, to the extent benefits were utilized by any **Dependent**(s) will result in those hours having been utilized to offset the appropriate cost of coverage for each month through the month in which the Trust Office is notified being deducted from the total of reserve account hours to have been frozen at the beginning of the **Employee's** period of military service. Any questions that arise concerning the interpretation of this clause shall be resolved by the Board of Trustees.

Notwithstanding the foregoing, any **Covered Employee** may elect to extend coverage for themself and their eligible **Dependents** under USERRA for a maximum of 24 months during his/her tour of duty in the military by paying the applicable COBRA cost of coverage. It should be noted that if the **covered employee** and their eligible **dependents** are covered by Kaiser, and leave the Kaiser service area, Kaiser will not be able to provide coverage during any period of USERRA leave. This provision is meant to, and shall be interpreted to, comply with the minimum requirements of the Uniformed Services Employment and Re-employment Rights Act of 1994.

THE NEWBORNS' AND MOTHERS' HEALTH AND PROTECTION ACT
(Newborns' Act)

This law includes important protections for mothers and their **children** with regard to the length of the hospital stay following childbirth.

Health plans are required to provide coverage for a minimum of a 48-hour stay for the mother and newborn following a vaginal delivery, and at least 96-hour maternity stay following a cesarean section. Under this new law, a mother and newborn can leave prior to the minimum stay, provided there is a mutual agreement between the mother and doctor. Each of the HMO medical plans under this **Plan** provide this maternity benefit.

If you have any questions, contact the Trust Office or your HMO directly for assistance.

Frequently Asked Questions About the Newborns' Act:

Q. *I am a pregnant woman. How does the Newborns' Act affect my health care benefits?*
A. The Newborns' Act affects the amount of time you and your newborn **Child** are covered for a hospital stay following childbirth. Group health plans, insurance companies, and health maintenance organizations (HMOs) that are subject to the Newborns' Act may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending **Provider** may decide, after consulting with you, to discharge you or your newborn **Child** earlier. In any case, the attending **Provider** cannot receive incentives or disincentives to discharge you or your **Child** earlier than 48 hours (or 96 hours).

Q. *Who is the attending physician?*
A. An attending **Provider** is an individual licensed under state law who is directly responsible for providing maternity or pediatric care to a mother or newborn **Child**. Therefore, a plan, hospital, or HMO would not be an attending **Provider**. However, a nurse midwife or physician assistant may be an attending **Provider** if licensed in the state to provide maternity or pediatric care in connection with childbirth.

Q. Under the Newborns' Act, when does the 48-hour (or 96-hour) period start?
A. If you deliver in the **Hospital**, the 48-hour period (or 96-hour period) starts at the time of delivery. So, for example, if a woman goes into labor and is admitted to the **Hospital** at 10 p.m. on June 1, but gives birth by vaginal delivery at 6 a.m. on June 12, the 48-hour period begins at 6 a.m. on June 12.

*Q. Under the Newborns' Act, may a group health plan, insurance company, or HMO require me to get permission (sometimes called prior authorization or pre-certification based upon medical necessity) for a 48-hour or 96-hour **Hospital** stay?*
A. A plan, insurance company, or HMO cannot deny you or your newborn **Child** coverage for a 48 hour stay (or 96-hour stay) because the plan claims that you, or your attending **Provider**, have failed to show that the 48-hour stay (or 96-hour stay) is medically necessary. However, plans and HMOs generally can require you to notify the **Plan** of the **Pregnancy** in advance of an admission if you wish to use certain **Providers** or facilities, or to reduce your out-of-pocket costs.

WOMEN'S HEALTH & CANCER RIGHTS ACT (WHCRA)

A federal law requires group health plans (HMOs and other insurers) providing coverage for mastectomies to also cover reconstructive surgery after a mastectomy. Prior to this law, the HMO plans generally already covered the services now mandated by the new law. The purpose of this section is to remind you and your **Covered Spouse** of the following:

Under federal law, group health plans and health insurance issuers that provide medical and surgical benefits with respect to a mastectomy must, in the case of a covered individual who is receiving benefits in connection with a mastectomy, provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications in all stages of the mastectomy, including lymphademas;

...in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions that are consistent with those established for other benefits under the **plan** or coverage.

Frequently Asked Questions About the WHCRA

Q. I've been diagnosed with breast cancer and plan to have a mastectomy. How will WHCRA affect my benefits?

A. Under WHCRA, group health plans, insurance companies, and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery, and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphademas.

Q. Will WHCRA require all group health plans, insurance companies, and HMOs to provide reconstructive surgery benefits?

A. All group health plans, and their insurance companies or HMOs, that provide coverage for medical and surgical benefits with respect to a mastectomy are subject to the requirements of WHCRA.

Q. Under WHCRA, may group health plans, insurance companies, or HMOs impose deductibles or coinsurance requirements for reconstructive surgery in connection with a mastectomy?

A. Yes, but only if the deductibles and coinsurance are consistent with those established for other benefits under the **plan** or coverage.

THE MENTAL HEALTH PARITY ACT OF 1996 (MHPA)
THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA)

As required by federal law, the San Diego Electrical Health & Welfare **Plan** is required to furnish you with information on the MHPA or MHPAEA. Generally speaking, the purpose of the MHPA & MHPAEA is to require group health plans that cover mental health conditions, and substance use disorders to provide parity in the application of lifetime dollar limits on mental health benefits and substance use disorders in the same manner as provided for medical conditions. As such health plans must cover diagnosis and treatment of severe mental illness (SMI) of persons of any age, and serious emotional disturbances of **Children**, under the same terms and conditions applied to other medical conditions including, but not limited to, maximum lifetime benefits, co-payments and individual and family deductibles. Benefits may include outpatient services; inpatient **Hospital** services; partial **Hospital** services; and prescription drugs, if the plan contract includes coverage for prescription drugs.

There are however many other provisions of the law which also allow health plans flexibility. For example, there is no requirement that health plans even provide mental health benefits.

Another important aspect of this law is that a health plan can choose to remove mental health benefits from their core medical plan, and offer a separate mental health plan (called a "carve out") with a totally separate set of benefits. For example, the **Plan** can require that all **Hospital** stays be approved, and further that the number of days of coverage be limited. There can also be limits on the number of outpatient visits for psychotherapy allowed under the **plan**.

Below is a simplified explanation of the benefits you are entitled to for mental health benefits under the San Diego Electrical Health & Welfare **Plan** for **Plan A** participants.

Plan A Trust Medical PPO Participants

Trust Medical PPO participants are covered for mental health and chemical dependency benefits under an exclusive agreement with MHN. You may review the Schedule of Benefits applicable to this coverage on page 20 of this Summary Plan Description. Of course, if you need further assistance or have questions you can always contact the San Diego Electrical Health & Welfare Trust Office.

Plan A Kaiser Participants

Kaiser members will receive benefit coverage for the diagnosis and medically necessary treatment of serious emotional disturbances (SED) of a **Child** and severe mental illnesses (SMI), of a person of any age. Covered benefits for the nine specific diagnoses are as follows: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder, anorexia and bulimia nervosa.

For a complete explanation of this benefit or if you have additional questions, you should contact the Kaiser Membership Services Department.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1998 (HIPAA)
Confidentiality of Health Information

Information Required by the Health Insurance Portability & Accountability Act (HIPAA)

Notice of HIPAA Special Enrollment Rights

Under HIPAA you and/or your Dependents are entitled to special enrollment rights if you declined coverage in this Plan because you and/or your Dependents had other group health coverage and you lose that other group health coverage. Additionally, you are entitled to enroll a newly acquired Dependent. However, you must request enrollment within 30 days of either the loss of the other coverage or the date you acquired the dependent to be eligible for this special enrollment right.

Effective April 1, 2009, you and your Dependents may also enroll in this Plan if you (or your Dependents) have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and you (or your Dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or SCHIP coverage ends.

Effective April 1, 2009, you and your Dependents may also enroll in this Plan if you (or your Dependents) become eligible for a premium assistance program through Medicaid or a State Children's Health Insurance Program (SCHIP). However, you must request enrolment within 60 days after you (or your Dependents) are determined to be eligible for such assistance.

Certification of Creditable Coverage Under HIPAA

The Plan will provide written certification of creditable coverage to you when your coverage ceases (under employer coverage and/or COBRA coverage) or when requested by you if your coverage is still in effect or if requested by you within two years after your coverage ends. The certification will specify the period(s) of creditable coverage under this Fund (including COBRA, if applicable) disregarding periods of coverage before a 63-day break. The 63-day break will not include any days between the loss of coverage and any secondary opportunity date to elect COBRA under the Trade Act of 2002.

If your coverage ends (under employer coverage and/or COBRA coverage), the certificate of creditable coverage will be provided to you automatically within a reasonable period of time after your coverage ceases. If you or someone on your behalf (including another health plan or issuer) wants to request a certificate of creditable coverage, please advise the Trust Office in writing at the following address:

You should provide your name and the name(s) of your dependent(s) and an address(es) to which the certificate(s) should be sent. The notice will then be processed and sent on the earliest date that the Plan, acting in a reasonable and prompt fashion, can provide it.

HIPAA Privacy Rules

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

PHI is defined as individually identifiable health information that is maintained or transmitted by this Plan in any form or medium (oral, written, or electronic). Individually identifiable health information is health information, including demographic information, that is created or received by a health care provider, employer, health care clearinghouse or this Plan and relates to the past, present or future physical or mental health condition of you or your eligible dependents, including payment information for the provision of health care.

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

1. Permitted Uses and Disclosures of PHI

This Plan and its Business Associates will use and disclose PHI without your authorization for purposes of treatment, payment and health care operations, but only the minimum amount of PHI necessary to accomplish these activities. Treatment includes but is not limited to the provision, coordination or management of health care among health care providers or the referral of a patient from one health care provider to another. Payment includes but is not limited to actions concerning eligibility, coverage determinations, coordination of benefits, adjudication of health benefit claims (including appeals), determinations of cost-sharing amounts, utilization reviews, medical necessity reviews, preauthorization reviews, and billing and collection activities. Health care operations include but are not limited to performing quality assessment reviews, implementing disease management programs, reviewing the competence or qualifications of health care professionals, underwriting, premium rating

and other insurance activities relating to creating or renewing insurance contracts. It also includes legal services and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business planning programs, and other related administrative activities.

2. Required Uses and Disclosures of PHI

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

3. Agreed to Uses and Disclosures of PHI by You after an Opportunity to Agree or Disagree to the Disclosure

This Plan will disclose PHI to family members, other relatives or close personal friends if the information is directly relevant to the family or friend's involvement with your health care or payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected.

4. Allowed Uses and Disclosures of PHI For Which Authorization or Opportunity to Object is Not Required

This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, worker's compensation programs and correctional facilities. These uses and disclosures are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices for Protected Health Information. Additional copies of these documents may be obtained from the Trust Office.

5. Your Individual Rights

HIPAA and the Privacy Rule afford you the following rights:

1. You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a request. If this Plan agrees, it is bound by the restriction except when otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction.

2. You (or your personal representative) have the right to request to receive communications of PHI from this Plan either by alternative means or at alternative locations. This Plan may agree to accommodate any such request if it is reasonable. This Plan, however, must accommodate such a request if you clearly state that the disclosure of all or a part of the PHI could endanger you. You will be required to complete a request form to receive communications of PHI by alternative means or at alternative locations.

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

4. You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a request form to amend PHI in a Designated Record Set. This Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide

a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

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

6. Access by Personal Representatives to PHI

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

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

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

7. This Plan's Duties

In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The Trust Office has designated this group of employees to include everyone on staff. The employees described above may only have access to and use and disclose PHI for plan administration functions. A mechanism shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

This Plan is required by law to provide you with its Notice of Privacy Practices ("Notice") by April 14, 2003, and thereafter, upon request. Also, the Notice must be distributed by this Plan to new employees and dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

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

8. Miscellaneous

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

This Plan may disclose summary health information to the Board of Trustees or a Business Associate. Summary health information is PHI, which includes claims history and claims experience, and from which identifying information has been deleted in accordance with the Privacy Rule.

This Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages it use or purchase. However, this Plan may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided under the plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.

9. Duties of the Board of Trustees With Respect to PHI

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have signed a certification agreeing not to use or disclose your PHI other than as permitted by the plan documents, the Privacy Rule, or as required by law.

10. Complaints

If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer at the following address: San Diego Electrical Health & Welfare Trust, PO Box 231219, San Diego, CA 92193-1219.

A complaint may also be filed with the HHS or its OCR, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, DC 20201.

All complaints must be in writing and filed within 180 days of the date you knew or should have known of the violation. This time limit can be waived if good cause is shown. This Plan will not retaliate against you for filing a complaint.

11. Security Standards Under HIPAA

The Board of Trustees will implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of electronic protected health information that the Fund creates, receives, maintains, or transmits on behalf of the Plan. The Trustees will ensure that the adequate separation required by the Privacy Rule is supported by reasonable and appropriate security measures. The Trustees will ensure that any agent, including a sub-contractor, to whom it provides electronic protected health information, agrees to implement appropriate safeguards to protect the information. The Trustees will report to the Plan any security incident of which it becomes aware.

You can contact the United States Department of Labor to seek assistance on your rights as provided by the Health Insurance Portability and Accountability Act (HIPAA). The office to contact is as follows:

United States Department of Labor
Employee Benefits Security Administration
1055 East Colorado Boulevard, Suite 200
Pasadena, CA 91106
(626) 229-1000

OTHER IMPORTANT INFORMATION

Name of **Plan**:	San Diego Electrical Health & Welfare Trust
Employer ID Number (EIN):	95-6035916
Plan Number:	501

Type of **Plan**:	**Trust** medical, dental and vision benefits are provided on a self-funded basis, except for optional prepaid medical and dental plans which are purchased pursuant to a contract with a service provider. All life insurance and accidental death & dismemberment benefits are purchased through a contract with an insurance carrier.
Type of Trust Administration:	The **Trust** is administered by a Board of Trustees under Trust Agreement executed jointly by equal representatives of the **Union** and **Contributing Employers**. Participants and beneficiaries may receive from the Trust Administrative Manager, upon request, information as to whether a particular employer or employee organization is a sponsor of the **Plan** and if the employer or employee organization is a plan sponsor, the sponsor's address. Further details may be requested from the Trust Office. The day to day administration of the Trust is administered by the San Diego Electrical Industry Administrative Corporation.
Plan Administration:	**Board of Trustees** of San Diego Electrical Health & Welfare Trust, P.O. Box 231219, San Diego, CA 92193-1219, telephone (858) 569-6322 or (800) 632-2569. Office hours: Monday through Friday, 8:00AM -12:00 Noon and 1:00 PM - 4:30 PM, excluding holidays.
Agent for Service of Legal Process:	Ken Stuart, Administrative Manager, 4747 Viewridge Avenue, Suite 100, San Diego, CA 92123-1688.

It is also possible that service may be made on any of the following **Trustees**:

Employer Trustees

Bruce Bailey
9350 Waxie Way, Suite 540
San Diego, CA 92123

Ted Baker
9350 Waxie Way, Suite 540
San Diego, CA 92123

Andrew Berg
9350 Waxie Way, Suite 540
San Diego, CA 92123

Robert Davies, Jr.
9350 Waxie Way, Suite 540
San Diego, CA 92123

Phil Petersen
9350 Waxie Way, Suite 540
San Diego, CA 92123

Union Trustees

Kevin Gorman
4545 Viewridge Avenue, Suite 100
San Diego, CA 92123

Terralyn Hartman
4545 Viewridge Avenue, Suite 100
San Diego, CA 92123

Nick Segura
4545 Viewridge Avenue, Suite 100
San Diego, CA 92123

Johnny Simpson
4545 Viewridge Avenue, Suite 100
San Diego, CA 92123

David Taylor
4545 Viewridge Avenue, Suite 100
San Diego, CA 92123

Relevant Provisions of the Collective Bargaining Agreement:	The Collective Bargaining Agreement between the San Diego Chapter, National Electrical Contractors Association, Inc. and Local 569, International Brotherhood of Electrical Workers, provides for **Employer** contributions to this **Trust** for each hour paid in all covered classifications. **Employee** contributions are required in an amount established by the **Trustees**. Copies may be obtained by participants and beneficiaries upon written request to the **Plan** Administrator and is available for examination.
Type of Funding:	Assets are accumulated in a **Trust** established to hold assets of the **Plan**. Disbursements of expense and benefit payments are through the **Trust**.
Plan Year (for benefits):	January 1st. to December 31st.
Fiscal Year:	October 1st. to September 30th.
Legal Counsel:	Melissa W. Cook & Associates San Diego, CA
Consultant:	Horizon Actuarial Services North Hollywood, CA
Administrator:	San Diego Electrical Industry Administrative Corporation San Diego, CA

HOW TO FILE A MEDICAL CLAIM
(This does not apply to prepaid medical/dental Plan participants)

1. Obtain the appropriate claim form from your Local **Union** or the Trust Office and complete in full. (If all questions are not answered it may be necessary to return the claim, which will delay payment.)
2. Attach fully itemized bills to the form.
3. It is important that each bill contain the right information, to include a diagnosis.

Each bill should include this information:

1. Name of **Covered Employee** and their Social Security Number;
2. Patient's name (submit separate claim forms for each person);
3. Date of each treatment;
4. Charge for each treatment;
5. Appropriate procedure code;
6. Nature of illness or injury; and
7. Type of service rendered

HERE'S WHY

"BILLS" are the "evidence" needed to pay claims. Any **Hospital** bills you receive will usually present full information, but other bills are sometimes incomplete. You can save time and assure yourself of prompt payment of benefits by having these bills complete and correct before you submit them.

HERE ARE SOME EXAMPLES:

Doctor's Bill
John R. Jones, M.D.
110 Main Street
Anytown

For Professional Services to: John A. Smith - Soc. Sec. #

Date of Treatment	Charge	Procedure Code #	Condition and Service
6/30/11	$ 150.00	99215	Office Visit-Established Patient
7/5/11	$ 200.00	99203	Office Visit-New Patient
9/20/11	$ 150.00	17001	Destruction of Lesion

(If surgery was performed, the Doctor should include the actual procedure code and/or a full description of the procedure.)

X-ray and Laboratory Bills

XYZ Laboratories, Inc.
James Roberts - Soc. Sec. #

Complete MRI - Shoulder, Arm and Hand
Procedure Code #73225
October 5, 2011
$2,000.00

1. Drug bills must include the prescription name and number, as well as the name of the prescribing **Physician**, quantity and cost. Do not submit bills for items which can be bought without a prescription.

Please do not submit canceled checks or cash register tapes. They do not contain the information necessary to process a claim.

CLAIMS AND APPEAL RULES

INTRODUCTION

The Claims & Appeal Rules described in this section do not apply to the following plans:

1. Kaiser HMO Medical Plan
2. Delta Dental Plan
3. MHN
4. Vision Service Plan
5. Prudential Life Insurance Company

Benefits provided by the above plans are subject to the claims and appeal rules established by each of the above providers. **Covered Persons** should contact that provider directly to address its claims review or grievance procedure.

The following rules have been adopted by the **Trustees** to cover claims and appeals for participants enrolled in any of the following plans:

1. Self-Funded Medical PPO Plan
2. Self-Funded Prescription Drug Plan

It is the intent and desire of the **Trustees** that these rules be consistent and comply with applicable regulations including, but not limited to, 29 CFR 2560, et seq., and Department of Labor Technical Releases Nos. 2010-01, 2010-02 and 2011-01, as amended, which are incorporated here as though set forth in full. The regulations shall be construed in accord with Department of Labor guidance issued subsequent to issuance of the regulations.

INTERNAL REVIEW PROCESS

For this Section the term "adverse benefit determination" or "denial shall each mean the denial, declination, reduction or termination of, or failure to provide or make payment in whole or in part for a benefit including any such denial, declination, reduction or termination of, or failure to make payment based on:

1. a determination of the claimant's eligibility status;
2. any recision of existing coverage (a rescission of coverage is the cancellation or discontinuation of coverage that has retroactive effect, except to the extent it is attributable to fraud, intentional misrepresentation of a material fact or non-payment of required payments to continue coverage);
3. a determination that a benefit is not a covered benefit;
4. a reduction in benefit resulting from the application of any utilization review decision or other limitation on otherwise covered benefits; or
5. whether a medical condition and/or the treatment of same is an **Eligible Medical Expense.**

The term "Claimant" shall mean the person on whose behalf the **Plan** denied coverage, access to medical service(s), or payment of a claim for medical service(s) for which an adverse benefit determination was issued by the **Plan**..

There are five types of claims that are covered by these Claims and Appeals Rules: Pre-service, Urgent, Concurrent, Post-service, and Disability claims.

PRE-SERVICE CLAIMS

Pre-service claims are claims for benefits that the **Plan** requires pre-authorization before a Covered Person receives medical care.

For non-urgent pre-service claims, the claimant or the claimant's physician will be notified of a decision 15 days from receipt of the Claim unless additional time is needed. The time for response may be extended up to 15 additional days if necessary due to matters beyond the control of the **Plan** or its designated service provider. If an extension is necessary, the claimant or the claimant's physician will be notified prior to the expiration of the initial 15 day period of the circumstances requiring the extension and the date by which a decision is expected to be rendered. If an extension is needed because **Plan** or its designated service provider needs additional information from the claimant or the claimant's physician, the extension notice will specify the information needed. In that case the claimant or the claimant's physician will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be denied. During the period in which the claimant is allowed to supply additional information, the period of making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date claimant responds to the request for additional information, which ever is earlier. The **Plan** or its designated provider then has 15 days to make a decision on the claim and notify the claimant of the determination.

A request for a determination on whether the Plan's coverage of a medical treatment or service that your physician has recommended, but the treatment or service has not yet been provided and the treatment or service is for care for which the **Plan** does not require pre-authorization, is not a Claim under these Claim and Appeals Rules. In this circumstance the the claimant or the claimant's physician should contact the **Plan's** designated PPO service provider listed in the front of this Summary Plan Description or on the **Covered Person's** ID Card.

URGENT CARE CLAIMS

For all of the **Plans** listed above, there are no pre-authorization (prior approval) requirements for claims involving urgent care. A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

1. Could seriously jeopardize the life or health of the claimant to regain maximum function, or

2. In the opinion of a physician with knowledge of the claimant's medical condition, would subjection the claimant to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim.

CONCURRENT CLAIMS

A Concurrent Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit. A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit, will be made by the **Plan** or an Independent Review Organization as soon as possible, but in any event early enough to allow the claimant or the claimant's physician to have an appeal decided before the benefit is reduced or terminated. Any request to extend approved treatment that does not involve urgent care will be decided according to Pre-service or Post-service time frames, whichever is applicable.

POST-SERVICE CLAIMS

Post-service claims are all claims that are not Pre-service, Urgent or Concurrent claims. Post-service claims are claims submitted on behalf of a **Covered Person** that involve only the payment or reimbursement of the cost of ~~the~~ **Eligible Expenses** pertaining to medical services that have already been provided. Completed claim forms or billings submitted to the Trust Office for reimbursement generate these claims. A claim regarding rescission of coverage will be treated as a post-service claim.

Prescription drug benefits are administered by Caremark utilizing a card-based system in which a claim is deemed to have been made when a **Covered Person** presents their Caremark identification card to a participating pharmacist or dispensary. The Trust Office administers the self-funded prescription drug program.

The Trust Office will review the claimant's post-service claim no later than 30 days from the date the claim is received. This 30 day period may be extended one time or up to 15 additional days if the Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies the claimant prior to the expiration of the initial 30 day period.

If an extension is needed because the **Plan** or an Independent Review Organization needs additional information from the claimant, the extension notice will specify the information needed. In that case claimant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the claim will be denied. During the period in which claimant is allowed to supply additional information, the period of making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date the claimant responds to the request for additional information, which ever is earlier. The **Plan** or an Independent Review Organization then has 15 days to make a decision on the claim and notify the claimant of the determination.

DISABILITY CLAIMS

The Trust Office will advise a **Covered Employee** no later than 45 days from the date of a denial of a claim for Disability Credit. However, the **Plan** may request any additional information deemed necessary to make a determination within the initial 45 day period. The **Covered Employee** must provide the requested information to the Trust Office within 45 days with a determination to be made within 30 days unless special circumstances exist, upon which an additional 30 days will be permitted.

NOTICE OF DECISION

The claimant or the claimant's physician will be provided with written notice of denial of claim in whole or in part. Notices will be sent by the Trust Office. The notice of denial will:

- Contain information sufficient to identify the claim, including a statement regarding the right to request the diagnosis code and treatment code (and their meaning);
- Give the specific reason(s) for the denial, as well as any Plan standards used in denying the claim;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim;
- A description of the Plan's internal appeal procedures and external review processes along with applicable time limits and information regarding how to initiate an appeal;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon written request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon written request at no charge; and
- Disclose the availability of, and contact information for, any applicable ombudsman established under the Affordable Care Act to assist individuals with internal claims and appeals and external review processes.

APPEALS PROCESS

Within 180 days after receipt of written notice that the claim has been denied, in whole or in part, the claimant, or his/her designated representative, must file a written appeal addressed to the **Board of Trustees** of the San Diego Electrical Health & Welfare Trust. You have the right to submit comments, documents, and other information in support of your claim for benefits. Upon written request, and free of charge, you will be provided with reasonable access to copies of all documents, records and other information relevant to your claim. You may include in a written notice a request for any applicable diagnosis and treatment codes for each denied claim, however such a request in itself shall not be considered a request for an internal appeal or external review. A document or other information is relevant if it was relied upon by the **Plan** in making the decision; it was submitted, considered or generated in connection with the claim (regardless of whether it was relied upon); it demonstrates compliance with the **Plan's** administrative processes for ensuring consistent decision-making; or it constitutes a statement of policy regarding the denied treatment or service.

Upon request, you will also be provided with the identification of medical experts, if any, that gave advice to the on your Claim, without regard to whether their advice was relied upon in deciding your claim.

DISABILITY AND POST-SERVICE CLAIMS APPEALS:

APPEALS WITHOUT A HEARING

Disability and Post-service claims appeals will considered at the next regularly scheduled meeting of the **Board** if the request for review is received at least thirty days prior to such meeting. Otherwise, the appeals shall be held at the second regularly scheduled **Board** meeting following receipt of the appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension is necessary.

APPEALS WITH A HEARING

You may also request that a hearing of your appeals before the **Board of Trustees**. If a hearing is requested, the **Board of Trustees** shall arrange for a hearing before the **Trustees** at the next regularly scheduled meeting of the **Board** if the request for a hearing is received at least thirty days prior to such meeting. Otherwise, the hearing shall be held at the second regularly scheduled **Board** meeting following receipt of the appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for hearing may be necessary. You will be advised in writing in advance if this extension is necessary.

The scope of such hearing shall be limited to the claim which was denied, the Documents used and relied upon by the **Trustees** in denying the claim, the pertinent Trust Documents, other evidence submitted in writing by the claimant as

provided below and a review of the issues and such other oral testimony as may be submitted. In order to permit the **Trustees** to seek any necessary outside review and/or consultation prior to the appeal hearing, all additional information and materials requested to be reviewed by the claimant must be received by the Trust Office at least 10 business days prior to the hearing date.

The claimant shall be notified in writing at least 15 days prior to the commencement of said hearing as to the date, time and location of such hearing. In the event the **Trustees** should desire additional comment or evidence on any issue involving the claim, a request for same may be made.

If the claimant should request an appeal hearing before the **Trustees**, the hearing will be conducted in accordance with the then current Hearing Procedures.

PRE-SERVICE CLAIM APPEALS

If appropriate, the Trust Office will send the appeal to an independent review organization. If your claim was denied based on a medical judgment, an independent health care professional who has appropriate training and experience in the relevant medical field will be consulted. The **Board of Trustees** or the appeals sub-committee of the **Board of Trustees** will then review all relevant information and make a determination on your appeal within 30 days of receipt of the appeal by the Trust Office.

ELIGIBILITY ISSUES

The Trust Office is responsible for maintaining eligibility records derived from payroll reports remitted by **Contributing Employers**. Each month the Trust Office provides certain benefit providers to the Trust with a listing of eligible participants, based on the most current information at the time the data is transferred. There may be instances where a claimant has a claim denied because he or she has not met the Rules of Eligibility to be eligible for benefits under the **Plan**.

If a claim is denied because a claimant does not meet the eligibility requirements of the **Plan**, the claimant has the right to appeal this denial. The appeal should be in writing and sent to the Trust Office. The appeal should include the reason(s) believed to have satisfied the eligibility requirements and include any factual information believed to be pertinent to the review. Appeals will be considered within the time parameters described in the sections above entitled “Pre-Service Claims” and “Post Service Claims” as applicable.

TIMING OF NOTICE OF DECISION ON APPEAL

- Disability and Post-service claims appeals will be made at the next regularly scheduled meeting of the **Board** if the request for review is received at least thirty days prior to such meeting. Otherwise, the appeals hearing shall be held at the second regularly scheduled **Board** meeting following receipt of the appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension is necessary. Once a decision on review of your claim had been reached by the **Board of Trustees**, you will be notified by the Trust Office of the decision no later than 5 days after the decision has been reached.

- For Pre-service claims appeals, you will be notified of the decision on appeal by the Trust Office within 30 days after receipt of the appeal by the Trust Office.

NOTICE OF DECISION ON APPEAL

The decision on any appeal fo your claim will be sent to the claimant or the claimant’s authorized representative. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination;
- Reference to the specific **Plan** provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to yoru claim,

upon written request and free of charge;

- A statement of your right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review;
- A statement of your right to external review, if applicable;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon written request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the **Plan** to your claim, or a statement that it is available upon written request at no charge.

Except for claims eligible for External Review, the decision of the **Board of Trustees** shall be final and binding upon all parties. However, if the **Participant, Retiree, Spouse** or **Beneficiary** is dissatisfied with the written decision of the **Trustees**, he or she shall have the right to appeal the matter to arbitration in accordance with the Employee Benefit Plan Claims Arbitration Rules of the American Arbitration Association, provided that he or she submit a request for arbitration to the **Trustees** within sixty days of receipt of the written decision of the **Board**. If an appeal to arbitration is made, the **Trustees** shall submit to the arbitrator a copy of the record upon which the **Trustees'** decision was made. The **Trustees** shall be responsible for the costs of such arbitration. However, the party requesting arbitration shall be responsible for his or her attorney's fees, if any. At the conclusion of the arbitration proceeding, the prevailing party may be entitled to recover their reasonable attorney's fees. The questions for the arbitrator shall be the following: (1) whether the **Trustees** were in error upon an issue of law; (2) whether the **Trustees** acted arbitrarily or capriciously in the exercise of their discretion; and (3) whether the **Trustees'** findings of fact were supported by substantial evidence. The decision of the arbitrator shall be final and binding upon all parties whose interests are affected thereby, unless a petition for judicial review is commenced within the statutory period for vacating an arbitration award.

In the event the **Plan** does not adhere to all requirements of this Internal Review Process, with the exception of violations deemed to be: de minimus, non-prejudicial, attributable to good cause or matters beyond the plan's control, in the context of ongoing good-faith exchange of information and not reflective of a pattern or practice of non-compliance, the claimant has a right request a written response from the **Plan**, which must be provided within 10 days as and include an explanation of the **Plan's** basis for asserting that the **Plan** has complied with these requirements or why an error should not cause the internal claims and appeals process to be deemed exhausted.

If the claimant skips the internal appeals process and files for external or judicial review, the external reviewer or court may reject the claimant's attempt at immediate review on the basis the **Plan's** violation was de minimis, in which case the claimant may resubmit the denied claim to the **Plan** and pursue an internal appeal. The **Plan** must notify the claimant of his or her right to resubmit the claim for internal appeal within 10 days after the external reviewer or court rejects the claimant's attempt at immediate external or judicial review, and the time period for refiling the claim begins to run upon the claimant's receipt of such notice.

EXTERNAL REVIEW PROCESS

The following External Review Process for a self-insured group plan is intended to comply with the Affordable Care Act ("ACA") and the Department of Labor Technical Release 2010-01 as amended and is effective January 1, 2012.

Generally, a **Participant, Covered Person**, former **Participant** or an Authorized Representative of a **Participant, Covered Person** or former **Participan**t may only request an External Review after he/she has exhausted the internal review and appeal processes described above.

Only claims that involve medical judgment (including, but not limited to, issues related to the medical necessity, appropriateness, the location of services, a level of care, the effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational) and rescission of coverage are eligible for External Review. However, claims pertaining to a contractual or legal interpretation of the terms of the **Plan** without any use of medical judgment are not eligible for External Review.

The Independent Review Organization ("IRO") is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The **Plan** may rotate assignment among IRO's with which it contacts.

Standard External Review:

Request for External Review - A **Participant, Covered Person** or a former **Participant Covered Person** may request an External Review within four calendar months from the date they received notice of an adverse determination or a final internal review adverse benefit determination. A notice sent via first class mail to the last known address reported to the Trust Office will be considered to have been received on the third business day following the date of said notice on the premise it was mailed on said date.

Preliminary Review - Within 5 business days following receipt of a request for External Review the **Plan** shall complete a preliminary review of said request to determine:

a. If the claimant was a **Covered Person** under the **Plan** at the time a request for medical service(s) was requested or at the time medical service(s) were rendered;

b. If the adverse benefit determination does not relate to failure of the person submitting the request to qualify as a **Covered Person** under the **Plan**;

c. If the claimant had exhausted the **Plan's** Internal Appeals Process as is required by the **Plan** (except, in limited, exceptional circumstances when under the regulations you are not required to do so); and

d. If the claimant has provided all information and documents required to process an External Review.

Within one business day of completing the Preliminary Review the **Plan** will notify the claimant in writing as to whether the claimant's request for External Review meets the above requirements. This notification will inform the claimant:

a. Whether the claimant's request is complete and eligible for External Review; or

b. Whether the claimant's request is complete but not eligible for External Review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

c. If the claimant's request is not complete, the notice will describe the information or materials needed to complete the request, and allow the claimant to request External Review within the four (4) month filing period, or within a 48 hour period following receipt of notification, whichever is later.

Review of Standard Claims by an Independent Review Organization ("IRO").

If the request is complete and eligible for an External Review, the **Plan** will assign the request to an IRO. Once the claim is assigned to an IRO, the following procedures will apply:

a. The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for External Review, including directions about how the claimant may submit additional information regarding the claim (generally, the claimant will need to submit such information within ten (10) business days).

b. Within five (5) business days after the External Review is assigned to the IRO, the **Plan** will provide the IRO with the documents and information the **Plan** considered in making its adverse determination.

c. If the claimant submits additional information related to the claim to the IRO, the assigned IRO must, within one (1) business day, forward the information to the **Plan**. Upon receipt of any such information, the **Plan** may reconsider its adverse determination that is subject of the External Review. Reconsideration by the **Plan** will not

delay the External Review. However, if upon reconsideration, the **Plan** reverses its adverse determination, the **Plan** will provide written notice of its decision to the claimant and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its External Review.

d. The IRO will review all the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the **Plan's** internal claims and appeals process. However, the IRO will be bound to observe the terms of the **Plan** to ensure that the IRO decision is not contrary to the terms of the **Plan**, unless the terms are inconsistent with applicable law. The IRO also must observe the **Plan's** requirements for benefits.

   In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate , may consider additional information, including information from the claimant's medical records, recommendations or other information from the claimant's treating health care providers, other information from the claimant or the **Plan**, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the **Plan's** applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer.

e. The assigned IRO will provide written notice of its final External Review decision to the claimant and the **Plan** within 45 days after the IRO receives the request for External Review.

f. The assigned IRO's decision notice will contain:

   (1) A general description of the reason for the request for External Review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), and reason for previous denial.

   (2) The date that the IRO received the request to conduct the External Review and the date of the IRO decision;

   (3) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

   (4) A discussion of the principal reason(s) for IRO's decision, including rational for its decision and any evidence based standards that were relied on in making the decision;

   (5) A statement that the IRO's determination is binding on the **Plan** and claimant (unless other remedies may be available to you or the **Plan** under applicable Federal law);

   (6) A statement that judicial review may be available to the claimant and the **Plan**; and

   (7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with External Review processes.

g. In the event a final decision of the Independent Review Organization may reverse an adverse benefit determination, in whole or in part, said decision shall be binding on the **Plan** which shall then process for payment all approved portions of each claim without delay even if the **Plan** may appeal, or seek judicial review of, the decision.

PART FOUR

QUESTIONS AND ANSWERS

ELIGIBILITY AND COST OF COVERAGE

Unless otherwise specified, all answers apply to Plans A, B and C.

Q. How many hours are required for initial or reinstated coverage under **Plan A or Plan B**?
A. An **Employee** must receive credit for 260 hours within 12 consecutive months.

Q. When will new or reinstated coverage under **Plan A or Plan B** go into effect?
A. Coverage will become effective the first day of the second month following the month in which the 260th hour was worked. Example: The **Employee** works 100 hours each in January, February and March. Their coverage will commence May 1st because the 260th hour was worked in March. If the **Employee** in the above example worked 130 hours each in January and February their coverage would become effective April 1st.

Q. How will I know I have qualified for new or reinstated coverage under **Plan A or Plan B**?
A. The Trust Office will send a package containing information pertaining to all coverages. It is recommended that participants track their hours may contact the Trust Office to facilitate this process after working their 260th hour.

Q. Who may be covered under new or reinstated coverage?
A. Under **Plan A** all eligible **Dependent**s of the **Covered Employee** will automatically be covered by the **Plan** for each month the **Employee** remains covered. Under **Plan B** the **Employee** cover age for their eligible **Dependent(s)** is optional and must be elected on a timely basis.

Q. Can I add my brother/sister/ parent/significant other to my coverage?
A. No. Eligible **Dependents** are an **Employee's Spouse,** unmarried natural **child**(ren), step-**child**(ren) and legally adopted **child**(ren). See definitions for details.

Q. When does a new **Dependent** become covered?
A. Under **Plan A,** at the moment of marriage, birth or placement in the **Employee**'s home for the purpose of adoption. Marriage, birth certificates and new Enrollment Cards should be remitted within 30 days. Under **Plan B** the above would apply if dependent coverage was in effect at the time of the event, otherwise **Dependent** coverage may only be added as part of the next open enrollment.

Q. Why are there two months between the work month and coverage month?
A. To permit contributing employers sufficient time to prepare and remit their monthly payroll reports (due by the 15th of the following month), and for the Trust Office to process all data and then send advance notices to those did not satisfy their cost of coverage so they can make a direct payment. Example: January hours are used to determine April coverage.

Q. Where do my excess hours in **Plan A** or **Plan B** go?
A. For **Bargaining Employees** any hours reported in excess of their monthly cost of coverage, up to maximum of 1,000 hours, will remain in their reserve account to be available to be used to maintain future coverage when less than the **Employee**'s required cost of coverage may be reported for a given month.

Q. Can I lose my coverage and reserve account hours if I work non-**Union**?
A. Yes. Coverage will immediately cease and all reserve account hours will be frozen. If you return to covered employment and re-qualify for coverage within 12 months then all frozen reserve account hours will be reinstated and become available on a prospective basis.

Q. If I am out of work will my coverage continue?

A. Yes, so long as there are sufficient hours in the **Employee**'s reserve account to cover their cost of coverage and they are eligible to use those hours in accordance with the Rules of Eligibility and/or they are eligible to make a Direct Payment or COBRA payment.

Q. If I am short hours can I pay to maintain coverage?

A. Yes, so long as the **Bargaining Employee** is eligible to do so in accordance with the Rules of Eligibility. Direct Payments are calculated by multiplying the number of hours the **Employee** is short by the then current **Plan A** portion of the overall Health & Welfare contribution rate.

Q. When is a Direct Payment due?

A. Even though the deadline for remitting a payment is the last day of the month it is recommended that payment be received by the end of the month before coverage terminates in order to avoid any delay in having coverage verified or claims paid.

Q. How long can I make Direct Payments to maintain continuous coverage?

A. The first 12 months of COBRA Continuation Coverage runs concurrent with the maximum of 12 consecutive Direct Payments. Provided a **Bargaining Employee** receives credit for at least 50 hours within a continuous 12 calendar months the period for remitting Direct Payments starts over. Once 12 consecutive months have elapsed without at least 50 hours being reported there will be a maximum of 6 more payments accepted for COBRA coverage (17 if **Totally Disabled**) in accordance with the Rules for Continuation Coverage.

Q. What is needed to properly enroll my family for coverage under **Plan A** or **Plan B**?

A. The initial enrollment package will contain an Enrollment Card, which must be completed and returned to the Trust Office. Birth Certificates with the parents names on them are required for all **Dependent Children**. Marriage certificates, as well as legal papers for step**children**, adopted **Children** and guardianship may also be required to properly establish dependency.

Q. When can I change my medical coverage under **Plan A**?

A. Each October all participants are given the opportunity to select their desired medical coverage, if applicable, for the upcoming calendar year commencing January 1st. If coverage is temporarily terminated during a calendar year, and is subsequently reinstated, the coverage previously in effect as of the date of termination will be reinstated for the balance of the calendar year.

Q. Until what age will eligible dependent **children** be covered?

A. Until they turn age 26.

Q. How do I designate my beneficiary for life insurance?

A. This may be done at any time by completing a new Enrollment Card.

Q. What is the monthly cost of coverage?

A. This is the minimum number of hours established by the **Board of Trustees** required to maintain **Plan A** or **Plan B** coverage. The cost of supplemental life insurance is reflected as additional hours derived from the current cost of such coverage and the current contribution rate. For **Plan C** this is the cost for medical and/or dental coverage(s) established by the **Board of Trustees**.

Q. Why might the **Plan A** HMO cost of coverage be so much more than the PPO plan?

A. The cost of coverage is determined taking into consideration actual operating and claim/premium costs associated with each **Plan**. If claim or premium costs for one **Plan** are much higher than for the other, the difference will be reflected in the monthly cost of coverage.

Plan A PPO SCHEDULE OF BENEFITS

Q. What is a PPO and who are PPO **Providers**?
A. A Preferred Provider Organization is a panel of **Hospitals**, **Physicians** and ancillary **Providers** who offer negotiated fee discounts to participants who use their services.

Q. How can I find out who are PPO **Providers**?
A. Each participant is provided a directory of all local panel **Providers** within the PPO or they can be located via the web site noted on the inside cover of this booklet or on the Identification Card.

Q. Are there PPO **Providers** outside San Diego County?
A. Yes, it is possible to access the national panel of PPO **Providers** via the web site noted on the inside cover of this booklet or on the Identification Card. There are now **PPO Providers** in certain parts of Mexico.

Q. What happens if I use a non-PPO **Provider**?
A. Since there are no discounts to the non-PPO **Provider** fees, the **Plan** will pay a lower percentage of the charges and the participant is obligated to pay the entire balance due.

Q. How much should I pay when using a PPO **Provider**?
A. Unless there is an office or drug co-payment required at the time of service nothing should be paid until you receive the Explanation of Benefits (pink copy) from the Trust Office reflecting the amount paid to the **Provider** and how much is owed under "Member Owes". Do not pay the portion of the charges identified as "PPO Discount".

Q. What is a **Pre-existing Condition**?
A. Any physical or mental condition for which a **Covered Person** sought care, medical advice, treatment or diagnosis within the 6 months immediately prior to their effective date of coverage. However, there is no **Pre-existing Condition** exclusion applicable to eligible **Dependent Children** under age 19.

Q. Are **Pre-existing Condition**s covered under the **Plan**?
A. Basically, there is no coverage for expenses relating to a **Pre-existing Condition** for the first 12 months of coverage. However, in accordance with **HIPAA** rules, the exclusion period may be shortened by each month the newly **Covered Person** can demonstrate they were covered by another group health plan for part or all of the 12 months immediately preceding their effective date of coverage.

Q. What is a calendar year deductible and how much is it?
A. This is the initial amount of **Eligible Expense** each calendar year (presently $250 per person) that the participant must pay before the **Plan** starts covering 80% of **Eligible Expenses**. However, office visit and prescription drug co-payments are not subject to a deductible.

Q. Is it possible not to have to satisfy a calendar year deductible?
A. Yes. If the full $250 deductible for a calendar year is satisfied by services rendered between October and December then that will also satisfy that **Covered Person's** deductible for the next calendar year.

Q. What is an office co-payment and how much is it?
A. This is the amount noted in the Schedule of Benefits that a participant must pay toward the charge for an office visit with a PPO **Provider**. Any other services by the PPO physician or all charges for services rendered by a non-PPO **Provider** will be processed in accordance with the Schedule of Benefits.

Q. What is the maximum out of pocket cost per calendar year under the PPO **Plan**?
A. Presently under the PPO **Plan** $1,500 (excluding office and drug co-payments) is the maximum that a **Covered Person** is required to pay after the calendar year deductible is satisfied. This means the **Plan** pays 80% of the first $7,500 of **Eligible Expenses** and 100% thereafter. Out of pocket costs for non-PPO **Providers** will be much higher.

Q. Is there a maximum amount of benefits payable in a calendar year?
A. Yes, presently the Schedule of Benefits provides for an annual maximum of $2,000,000.

Q. Do I need a select or go through a primary care physician under the PPO **Plan**?
A. No.

Q. Can I select my own **physician/hospital/facility** under the PPO **Plan**?
A. Participants may select any **Provider** desired, preferably from within the PPO in order to receive the discounts and higher **Plan** reimbursement levels.

Q. Do I have to use a **Hospital** emergency room for emergency services?
A. No. Physician's offices or free-standing **Urgent** care facilities should be used when there is a viable alternative and time is not of the essence. The costs for such services will be much lower. Unless the patient is admitted to the **Hospital** from the emergency room a much lower portion of the bills will be covered by the **Plan**.

Q. Should I use a **Hospital** for out-patient laboratory and x-ray services?
A. No. Using a physician's office or Non-**hospital** laboratory/radiology facility will be much less expensive as **Hospitals** do not have pre-negotiated fees under their PPO Agreements.

Q. Does the **Plan** cover chiropractic/acupuncture services?
A. Yes. However, there are daily and calendar year limits noted in the **Plan**.

Q. What are usual & customary fees?
A. The fee usually and customarily charged by other than **Hospitals** for the service in a particular geographic area. Since all PPO **Providers** have agreed to a negotiated discount schedule these represent the usual and customary charge for that service to be considered under the **Plan**.

Q. What happens if an **Employee** or their **Spouse** is covered at the same time under more than one group health plan?
A. The **Plan** will "coordinate" between the two or more coverages so that no more than 100% of **Eligible Expenses** will be paid. The plan covering the **Employee** or **Spouse** as the insured will always be primary and any other coverage will be secondary.

Q. Which plan would be primary for **Dependent Children**?
A. The plan of the parent whose birthday falls earlier in the calendar year will be primary, regardless of which parent is older. This process can be more complicated if there are additional coverages resulting from applicable domestic relations orders.

Q. Why are there two ID cards in the enrollment package?
A. So the **Employee** and their **Spouse** or other **Dependent**(s) may have a card in their possession. Additional cards may be requested from the Trust Office.

Q. What information is on the Trust ID card?
A. Information outlining important features and requirements of the **Plan**, as well as telephone/web site access to all service **Providers**.

Q. How long does it take to receive an CVS/Caremark prescription ID card?
A. CVS/Caremark cards must be ordered and will take a few weeks to be provided to the Trust Office and then forwarded to the **Covered Employee**.

Q. Where should I go to fill a prescription?
A. To any participating CVS/Caremark pharmacy.

Q. How much do I pay when filling a prescription?
A. When using an CVS/Caremark pharmacy a 20 % co-payment is payable for generic and preferred brand name drugs. Non-preferred brand name drugs will cost much more.

Q. Are generic drugs required?
A. Yes, whenever a generic alternative exists. If not, one of the preferred brand names on a list established by CVS/Caremark is recommended.

Q. What are the co-payments for prescription drugs?
A. For generic (when available), preferred brand names or a brand name for which there is no generic or preferred alternative, the co-payment will be 20%. If a brand name drug is purchased when a generic or preferred alternative exists the charge will be the full cost of the prescription less 20% of the cost of the generic or preferred brand name alternative.

Q. When is mail-order service required for prescriptions?
A. Mail-order through CVS/Caremark is required for all maintenance drugs (i.e. any medication expected to be taken regularly for at least one year) as determined by CVS/Caremark. Mail -order maintenance drugs are usually issued for a 90 day supply. Only the initial prescription for a 30 day period for a new maintenance drug may be filled locally, however it is possible to get a 30 day supply only at CVS pharmacies.

Q. What is the Members' Assistance Program (MAP)?
A. The MAP is a network of clinically trained mental health specialists.

Q. Are there separate **Providers** for mental health benefits?
A. Yes. The **Plan** provides for a series of free sessions for assessment and counseling through the Members' Assistance Program (MAP), as well as out-patient/in-patient mental health and substance abuse coverage through an exclusive contractual arrangement with another **Provider**. For other than emergency **Hospital** admissions it is required that the MAP be accessed to receive a referral for all mental health/substance abuse treatment.

BEST DOCTORS AND SATORI WORLD MEDICAL

Q. What is Best Doctors?
A. A program started by physicians from Harvard Medical School in 1990 offering confidential independent expert medical reviews of serious diagnoses and/or severe treatment plans, surgeries and/or medication therapies which is available **at no cost to the participant**.

Q. Why should one contact Best Doctors?
A. To validate a medical diagnosis and/or treatment plan in an effort to "get it right".

Q. What are the main reasons to contact Best Doctors?
A. No diagnosis, not understanding a diagnosis, symptoms not improving, questions as to the need for recommended surgery, or a need for help in deciding between multiple proposed treatment options.

Q. How do I contact Best Doctors?
A. To find out more about the Best Doctors program or services call 1-866-904-0910 or go to www.bestdoctors.com . You may also send your diagnosis or treatment plan through to Best Doctors via email at info@bestdoctors.com.

Q. What are Satori World Medical "Centers of Excellence"?
A. A network of hospital facilities and specialists throughout the U.S. which have become recognized as leaders in cardiac procedures, cancer treatment and transplant programs. Use of these facilities is voluntary.

Q. Why should one contact Satori World Medical?

A. Access to this program, which is available **at no cost to the participant,** will provide assistance in identifying facilities proven to be of the highest reputation for the type of services and/or treatment necessary.

Q. What are the main reasons to contact Satori World Medical?

A. To seek medical services from providers recognized as the "best of the best" to achieve the best possible medical outcome for the patient.

Q. What should one expect when contacting Satori World Medical?

A. Direct case management by well-trained staff to assist PPO participants dealing with a complicated or extreme surgical procedure/medical plan of treatment to choose the most appropriate Center of Excellence, coordinate with all physicians, specialists and facilities, including making all necessary travel and accommodation arrangements.

Q. How do I contact Satori World Medical?

A. To find out more about Satori World Medical providers or services call 1-866-613-9686 or go to www.satoriworldmedical.com .

HEALTH MAINTENANCE ORGANIZATION (HMO) BENEFITS (For Plans A, B & C)

Q. What are the advantages of an HMO?

A. Under an HMO **Plan**, covered benefits are provided for either no charge or for a fixed co-payment so long as HMO physicians and facilities are used.

Q. Under an HMO, can I select my primary care physician?

A. Yes, provided the physician is an HMO physician under the **Plan** you selected. Each family member is encouraged to select a primary care physician who must be consulted first for all non-emergency treatment.

Q. Can I change my primary care physician?

A. Yes, you are allowed to change to another primary care physician at any time.

Q. What if I go to a or facility outside of my HMO?

A. Unless the HMO you selected referred you to a specialist, there are no benefits available if you use a physician or facility outside of the HMO.

Q. Are services for medical emergencies a covered benefit under an HMO?

A. Generally yes, subject to the established rules of the HMO. The HMO has specific benefits for emergency services, within or outside the HMO service area.

Q. Must I live in an HMO service area in order to be covered by the HMO?

A. Yes, you must reside in a zip code area recognized by the HMO.

DENTAL AND VISION BENEFITS

Q. Should I use only Delta Dental **Providers**?

A. Yes, in order to obtain maximum coverage and lowest out-of-pocket costs.

Q. Are there different benefits payable within the Delta Dental program?

A. Yes, higher benefits are payable when a PPO **Provider** is used as opposed to all other Delta Dental Premier **Providers**. PPO **Providers** also charge the **Plan** less than other Delta Dental **Providers**.

Q. What is the Delta Dental group number?

A. #1978.

Q. How much should I pay the dentist at the time of service?
A. Usually there is little or nothing due for routine cleaning/x-ray/filling services. For other services it is possible the **Provider** will ask you to pay the estimated portion not to be paid under the dental schedule of benefits. Actual out of pocket cost will depend on which Plan is being used.

Q. Must I use only Vision Service Plan **Providers** (**Plan A** and **Plan B**)?
A. Yes, in order to obtain maximum coverage and lowest out-of-pocket costs.

Q. How much should I pay the eye doctor at the time of service?
A. It is customary to pay the applicable deductibles for an office visit and/or pair of glasses, as well as the required portion of all scheduled allowances.

Q. How is my dental/vision coverage verified?
A. The service **Provider** will verify coverage through the appropriate dental/vision program.

Q. Is there a limit to dental/vision coverage each year?
A. Yes, there is a specific schedule of calendar year benefits.

Q. May I be reimbursed when using non-Delta Dental/VSP **Providers**?
A. Yes, it will be necessary to first pay for all such services and then remit the claim to the appropriate program. Reimbursement will be in accordance with a predetermined schedule.

SPECIFIC SERVICE PROVIDERS
Blue Cross (a Preferred Provider Organization/PPO):

Q. How do I locate a Blue Cross panel **Provider**?
A. In the directory of local PPO **Providers** obtainable through the Trust Office, by calling (888) 685-7774 or at www.anthem.com/ca

Q. Do I need to designate a primary care physician to receive benefits?
A. No.

Q. May I choose my own **physician/hospital/facilities**?
A. Yes.

Q. Are there Blue Cross **Providers** outside San Diego County?
A. Yes. Blue Cross is a national program that can be accessed calling (888) 685-7774 or at www.anthem.com/ca.

Q. Can a **Provider** outside the United States be used?
A. The PPO **Plan** provides coverage anywhere in the world. There can be difficulties in converting billed charges into US dollars and getting complete explanations for the actual services rendered.

Q. Should I make any payment to a Blue Cross **Provider** at the time of my visit?
A. Only a co-payment if there is a charge for an office visit.

SIMNSA PPO (presently in Tijuana, Mexicali and Tecate):

Q. How do I locate a SIMNSA panel **Provider**?
A. By calling (619) 407-4082 or at www.simnsa.com.

Q. Do I need to designate a primary care physician to receive benefits?
A. No.

Q. May I choose my own **physician/hospital/facilities**?
A. Yes.

Q. Should I make any payment to a SIMNSA **Provider**?
A. Only a co-payment if there is a charge for an office visit.

Sharp Rees-Stealy:

Q. Is Sharp Rees-Stealy a PPO **Provider**?
A. Yes. Any **Provider** and facility of Sharp Rees-Stealy will be considered a PPO **Provider**.

Q. How do I locate a Sharp Rees-Stealy **Provider**?
A. You may contact (800) 827-4277 or www.sharp.com

Q. What basic services are available through Sharp Rees-Stealy?
A. Varying Non-**hospital** services are available at some or all Sharp Rees-Stealy facilities.

Q. Are there emergency care facilities available?
A. Yes, subject to announced hours at some or all Sharp Rees-Stealy facilities.

Q. How do I schedule a routine physical exam?
A. You must call (858) 616-8411 to make an appointment with the Sharp Rees-Stealy Occupational Medicine Facility. If you do not make an appointment through this number the charges for any routine exam services will be paid in accordance with the regular schedule of benefits and will result in a substantially higher out of pocket cost.

Q. Can I take a NECA/IBEW drug test at Sharp Rees-Stealy?
A. Yes, but only at specific facilities. Contact the Trust Office to learn which are participating facilities. These are not Health & Welfare or PPO related services.

Blue Cross of Southern California (other than PPO services):

Q. What is **Hospital** pre-certification?
A. If a physician recommends that a participant be **Hospital** confined the admission must be presented by the physician's office to Blue Cross and pre-certified as being due to medical necessity and that sufficient treatment may not be readily obtainable on an out-patient basis. This also permits monitoring as to how long the **Hospital** confinement may continue and notifying case management for serious cases.

Q. What is case management?
A. When a **Covered Person** is seriously hurt or ill, and treatment is expected to last a long time and/or be very expensive, then a case manager will be assigned to oversee the course of treatment to not only ensure that the patient is receiving proper and appropriate care, but to also monitor the cost of same and participate with the attending physician(s) in arranging for quality treatment plans that could be less expensive whenever possible.

Q. Must I use or accept a case manager?
A. Yes, this is not optional.

Q. Are case management services rendered only while **Hospital** confined?
A. No. **Hospital** confinement is not a prerequisite as any plan of treatment expected to be long lasting and/or costly will be monitored by a case manager.

Pacific Foundation for Medical Care (provides medical necessity and utilization reviews):

Q. What is medical necessity?
A. Any service that is deemed necessary for the treatment of, or due to, a medical condition. In other words, services for which there is no diagnosis or specific medical reason would not be covered under the **Plan** as being routine and not medically necessary.

Q. Must all forms of therapy be prescribed by physician?
A. Yes, the same as with any prescribed medication.

Q. Must all forms of therapy, (physical, speech, etc.) be pre-authorized to be covered? Is there a maximum number of therapy visits?
A. Yes. While all therapy requires a physician's prescription, it is necessary for more than 6 visits to be pre-authorized in order to be covered by the **Plan**.

Members' Assistance Program/MHN:

Q. What is the Members' Assistance Program (MAP)?
A. The MAP is a network of clinically trained mental health specialists providing confidential assessment and counseling services.

Q. How do I access the MAP?
A. Call (800) 342-8111 or visit www.horizoncarelink.com.

Q. Who may use the MAP?
A. Any **Employee** and their eligible **Dependent**(s) who are covered by the **Plan** at the time of treatment.

Q. What is the cost for using the MAP?
A. There is no cost for up to 8 sessions over any 12 consecutive month period.

Q. What services does MHN provide?
A. Out-patient and in-patient treatment for mental health and substance abuse conditions.

Q. How is MHN accessed?
A. For other than an emergency **Hospital** admission the **Employee** or **Dependent** must first access the MAP for an initial assessment and referral to MHN.

Q. Are there maximums for in-patient and out-patient services?
A. Yes. Please refer to the schedule of benefits and descriptive content.

Q. Are there out-of-pocket costs for MHN **Providers**?
A. Yes. Please refer to the schedule of benefits and descriptive content.

GENERAL SECTIONS (under Plan A):

Auto or serious Accidents:

Q. If a **Covered Person** is in an auto or a serious accident, how should the **Plan** be notified?
A. As soon as possible after the accident please contact your claims examiner.

Q. Will the **Plan** cover expenses related to an auto or serious accident?

A. Yes, in the same manner as any other expenses except that every effort will be made to defer portions of these expenses to any other possible source of coverage such as the third party responsible for the accident and/or auto and homeowner's insurance policies.

Q. What is "Subrogation"?

A. In a situation where a loss is caused by a third party, the **Plan** will attempt to recover ("subrogate") related medical claim payments from or through that party in an effort to reduce overall claim payments and keep contribution and co-insurance costs as low as possible.

Q. Must the injured person sign a Subrogation Agreement?

A. Yes. As a condition for the **Plan** to make payment of all pending medical bills, while awaiting completion of often tedious and long term legal/insurance processes, the person must execute a Subrogation Agreement through which the **Plan** will be reimbursed for claim payments pursuant to a schedule associated with the actual amount of the person's actual net recovery after deducting legal fees and costs.

Work Related Injuries/Illnesses:

Q. Will the **Plan** cover work related injury/illness expenses?

A. Technically, the **Plan** does not cover claims for services related to any work related injury or illness due to the presumed existence of workers' compensation coverage. However, in the event there is a conflict over whether the claim is actually work-related it is possible for the **Plan** to make advance payment subject to the injured person executing a lien to be placed on their workers' compensation claim so that the **Plan** may be reimbursed if an affirmative determination is made that the claim is work-related. Depending on the situation it is also possible that a Subrogation Agreement may be required prior to the **Plan** making any payments.

Q. If a **Covered Person** sustains a work related injury or illness, how should the **Plan** be notified?

A. As with any accident or first time treatment, a claim form is required to be filed with the Trust Office for the purpose of providing the details of the incident. The question as to whether this is work-related should be answered "yes".

Q. What is a workers' compensation lien?

A. It is a claim placed on the workers' compensation action to provide for the **Plan** to be reimbursed once a determination is made as to whether there was a work related injury/illness.

Claim Forms/Explanation of Benefits Form ("EOB"):

Q. Why are claim forms required?

A. To provide the Trust Office with current information such as address, **Dependent** status, existence of other group health coverage and to explain the details of any accident.

Q. How often are claim forms required?

A. For the first claim per **Covered Person** for each calendar year, as well as for each accident or new illness or as may be requested by the Trust Office.

Q. What is an EOB?

A. An Explanation of Benefits form is an actual copy of a payment check or claims adjudication explanation containing information regarding the billed charges and how the amount of payment was determined. There may also be an explanation as to why part or all of any billed charge was deemed ineligible. The appeals process is on the back of the EOB.