

# **SAN MATEO ELECTRICAL WORKERS HEALTH BENEFIT AND DISABILITY PLANS**

**(For Members of IBEW LOCAL 617)**

## **SUMMARY PLAN DESCRIPTION ACTIVE EMPLOYEES**

**July 1, 2008**

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**ALERT**

The Benefits provided under this Plan may be changed at any time. The Board of Trustees may reduce or eliminate any benefits and may change or eliminate insurance carriers, HMOs, PPOs, or any other entity to make additional contributions for coverage at any time.

The benefits in this Summary Plan Description are as of the date prepared. Any subsequent amendments will govern the actual benefits payable.

## **FOREWORD**

Dear Participant:

This booklet known as a Summary Plan Description contains general information regarding your Medical Benefits and an explanation of the eligibility provisions. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Administrative Office at (408) 288-4400.

Please remember that this booklet is only a summary. In the event of any dispute, the official language of the group insurance policy, or other master agreements, will be in control.

*For details on your benefit coverage, please refer to the Insurance Providers' Evidence of Coverage. The Evidence of Coverage is the binding document between the Insurance Plan and its participants.*

The provider has discretion to make any factual determination concerning your plan.

The Board of Trustees has authorized the Administrative Office to respond in writing to your written questions. If you have an important question about your benefits, you should write to the Administrative Office for a definitive answer. The Administrative Office is located at:

United Administrative Service  
1120 S. Bascom Avenue  
San Jose, CA 95128-3590  
Phone: (408) 288-4400

Open Enrollment is held each year, from April 16<sup>th</sup> through May 15<sup>th</sup>, you may elect to change your benefit plan options selection by completing a new enrollment card through the Administrative Office. Your change, which must be received by the Administrative Office by May 15<sup>th</sup> and will be effective June 1<sup>st</sup> of that year. Provider benefit booklets are available at the Administrative Office or at the Local Union Office.

As a courtesy to you, the Administrative Office may also respond informally to oral questions. However, oral information and answers are not binding upon the Board of Trustees or the Plan and cannot be relied upon in a dispute concerning your benefits.

Plan rules and benefits may change from time to time. The Plan will provide you with a summary of important material changes. You may also receive replacement pages for this booklet. Please be sure to read all Plan communications and keep your booklet up to date by adding replacement pages as soon as you receive them.

## **ELIGIBILITY REQUIREMENTS**

### **Initial Eligibility**

When you enter an eligible class you become eligible for coverage under this Plan on the first day of the second month after the month in which you have accumulated to your credit a minimum total of 600 hours of employment with Participating Employers.

### **Covered Dependents**

Your Covered Dependents are your lawful spouse (husband or wife), natural children, legally adopted children and stepchildren.

Dependent child shall be:

1. A blood descendent of the first degree;
2. A legally adopted child, including children living with adopting parents during the period of probation and children for whom the adopting parents have assumed and retained a legal obligation to provide total or partial support in anticipation of adoption;
3. A stepchild residing in the employee's household; and
4. A child residing permanently with the employee, who is head of the household, and who is being solely supported by the employee. Except for children who have been or are being adopted by the employee, the child must be related by blood or marriage to the employee, or the employee must be the child's legal guardian;
5. During the period you continue to have coverage, any new eligible dependents you acquire may be added in accord with the dependent's eligibility provisions, and any eligible dependents you decline to insure before your continued health coverage began may be added during any open enrollment period provided by the plan. Coverage will be immediate for all dependents without any preexisting condition limitations;
6. Covered Dependents are eligible for all benefits provided from birth through the age of 18 years, provided such children are unmarried, and dependent upon their parents for support and maintenance, and reside with you in a parent-child relationship. Children also include those from age 19 years up to age 25 years provided they are attending an accredited and state licensed technical school or institution of higher education on a full-time basis, are unmarried and are dependent upon you for support and maintenance.

A dependent child also includes a child after their 19<sup>th</sup> birthday for all benefits provided herein provided the child is both:

Incapable of self-sustaining employment by reasons of mental handicap or physical handicap and chiefly dependent upon you for support and maintenance.

Such qualifications will continue coverage for the child beyond their 19<sup>th</sup> birthday.

The Administrative Office must receive proof of such incapacity and dependency within 31 days of the child's 19<sup>th</sup> birthday. **THAT IS YOUR RESPONSIBILITY.** The Plan or Trust may require, at reasonable intervals following the child's 19<sup>th</sup> birthday, proof of the child's continued disability and dependency.

No dependent can ever be deemed a Covered Dependent unless he or she is a dependent of a Covered Employee.

### *Domestic Partners*

A Covered Employee's domestic partner will be covered provided the domestic partnership meets the following criteria:

- 1) Both persons must file a Declaration of the Domestic Partnership with the Secretary of the State of California and provide a copy to the Administrative Office;<sup>\*1</sup>
- 2) Both persons must have a common residence;
- 3) Neither person may be married to someone else or be a member of another domestic partnership with someone else that has not been terminated;
- 4) The two persons must not be related by blood in any way that would prevent them from being married to each other;
- 5) Both persons are at least 18 years old;
- 6) Both persons must be members of the same sex, or, if opposite sex, one or more persons must be over age 62; and
- 7) Both persons must be capable of consenting to the domestic partnership.

In addition to the above requirements, both the Covered Employee and the domestic partner agree to inform the Administrative Office of the termination of their domestic partnership as a result of a change in one or more of the above requirements or the death of the domestic partner.

The election by a Covered Employee to add a domestic partner may have certain Federal income tax implications. Under Federal tax law, the fair market value of health coverage provided to a domestic partner is a taxable benefit to the Employee. (Please note that domestic partner benefits are not taxable under California law.) Each year the Fund will

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<sup>1</sup> For those Employees who do not live in the State of California and are, therefore, not eligible to file a Declaration of Domestic Partnership with the Secretary of State's Office, the Fund will accept a properly completed Affidavit of Domestic Partnership as proof of the domestic partnership so long as the criteria set forth in 2-7 above is met. The Administrative Office will provide Employees with the Affidavit upon request.

calculate the fair market value of the domestic partner coverage and this information will be sent to participating employers. The Employee's employer is then responsible for including the imputed income on the Employee's wages and withholding any FICA, FUTA, Medicare and Federal income taxes as applicable.

The Plan may require evidence of continued disability and dependent status at any time.

### **Automatic Coverage for a Newborn Child**

While your Employee Medical Expense coverage is in force, a newborn or newly adopted child of any age, will automatically be covered for the first 31 days of medical benefits on the date the child becomes a Dependent whether or not you have applied for Dependent coverage.

Dependent coverage is automatically provided for the first 31 days for newborns or for a newly adopted child, however, you are required to apply for Dependent coverage for that child within 31 days of the child's birth or of the adopted child's placement in your home in order to continue that child's coverage beyond the first 31 days.

If you are required to contribute toward the cost of insurance and if the child's coverage terminates because you fail to apply (or pay the required contribution) within the 31-day period, benefits will be payable only for covered expenses incurred by the child while coverage was in force. The Individual Purchase Rights and the extended Benefits (after termination of coverage) will not apply to the child.

The Plan will comply with any medical child support order, which is "qualified" under federal law, as determined by the Administrative Office. However, no such order, assignment or claim may require the Plan to provide benefits to someone not eligible under the rules of the Plan or to provide benefits in excess of amounts stated in the applicable description of benefits.

### **Qualified Medical Child Support Orders**

The Plan will comply with any Medical Child Support Order (MCSO), which is "qualified" under federal law, as determined by the Administrative Office. However, no such order, assignment or claim may require the Plan to provide benefits to someone not eligible under the rules of the Plan or to provide benefits in excess of amounts stated in the applicable description of benefits. Upon service with a Medical Child Support Order, the Administrative Office will review the MCSO under procedures adopted by the Trustees, and determine within a reasonable time whether or not the MCSO is a Qualified Medical Support Order. The determination that a MCSO is not a Qualified Medical Child Support Order is subject to the Plan's appeals procedure. A copy of the Plan's procedures for administering Qualified Medical Child Support Orders may be obtained from the Plan Administrative Office.

## RESERVE ACCOUNT

### Reserve Account

A separate reserve account also known as an hour bank will be maintained for each person showing an accumulation of hours worked for Participating Employers. After qualifying as provided above under Initial Eligibility, an hourly charge per month for coverage shall be based on the medical plan selected as follows:

Kaiser Plan	120
Self-Insured Fund	120

This charge is made against your accumulated reserve hours when sufficient hours remain in reserve. If you work more than 120 hours during a month, the excess hours will be banked in your reserve account. Hours worked in one month shall not apply toward coverage the next month, but in the second following month. For example, hours earned in March will provide coverage in May.

After 12 months of no activity, a member's reserve account is removed, and upon return to work in the local union, the member must requalify for eligibility.

### Maximum Reserve

You may accumulate a reserve not to exceed 1200 hours, to be used in the future to supplement insufficient hours and shall have no credit for hours reported in reserve exceeding 1200 hours.

### Residual Hours

If you have not had coverage for a period of twelve consecutive months or more, any residual hours in your Reserve Account are forfeited; and thereafter, should you again perform work covered by the Collective Bargaining Agreement, or through the National Reciprocity plan as applicable, you are required to reestablish eligibility under the "INITIAL ELIGIBILITY" provision above.

### Self-Payments/COBRA

In order to maintain continuous coverage, a participant whose coverage has terminated or has insufficient hours for coverage, may elect to continue coverage under one of the two options:

#### OPTION ONE:

You may elect to continue the total benefit package (Life, AD&D, Medical and Dental coverages) for up to twelve consecutive months, at a cost equal to 100% of the full amount of

the cost of the benefits as determined by the Trustees or a participant may elect to continue the total package if actively seeking employment and is available for dispatch, has been dispatched, or is working in the jurisdiction of Local Union 617, at a cost to be determined periodically by the Trustees.

If this option is selected, the twelve consecutive months of coverage provided shall run concurrently with the first twelve months of coverage under Option Two COBRA as if you or your eligible dependents were covered under Option Two initially. Should a dependent's coverage terminate under Option One (e.g., due to divorce or a dependent child losing eligibility because of age), that dependent may continue coverage under Option Two up to a maximum of thirty-six months of coverage under Option One and Option Two combined.

**OPTION TWO:**

**COBRA**

<b>IF YOUR COVERAGE ENDS BECAUSE OF:</b>	<b>COVERAGE MAY CONTINUE FOR UP TO:</b>
<p><b>Termination of employment (for any reason other than gross misconduct) or reduction in work hours</b></p>	<p><b>18 Calendar Months*</b></p> <p><b>(*29 Calendar Months (18 Calendar Months plus an additional 11 Calendar Months), if employment ends due to termination of employment or reduction in hours, and at any time during the first 60 days of continuation coverage, the Member or his or her Dependent is totally disabled (as determined by Social Security)).</b></p>
<p><b>Death of Member</b></p> <p><b>Member's entitlement to health care coverage under Medicare</b></p> <p><b>Legal separation, divorce, cessation of domestic partnership</b></p> <p><b>Dependent Child no longer qualifies for Dependent coverage under the Plan</b></p>	<p><b>36 Calendar Months for Dependent</b></p>

For further details on COBRA, refer to Continuation of Coverage section, page 11.

## **Employee – State Required – California – Coverage - If Labor Dispute**

Notice: Arrangements may be made to continue your coverage if you cease Active Work because of a labor dispute. You may continue your coverage up to six months, but only if certain conditions of the Insured arrangements are met. See your *Participating Employer* to make arrangements for continuing your coverage. Your coverage will be terminated unless you make arrangements within 31 days after you cease Active Work due to a labor dispute.

### **TERMINATION OF COVERAGE**

Except as provided under the Self Payments provision, an employee and dependents who have been eligible for the benefits of this Plan shall cease to be eligible for the benefits on the earliest date of:

#### **Employee**

Employee coverage will terminate on the earlier of:

1. The date the person is no longer eligible under the Plan because he or she has less than 120 hours in his or her reserve account.
2. The date of termination of the Plan or, if any benefit of the Plan is terminated, on the date of termination of such benefit.

#### **Dependent**

Your Dependent coverage will terminate on the earlier of:

1. The date the person ceases to be a dependent as defined in the Plan.
2. The date that the person who has Covered Dependents ceases to be eligible under the Plan.
3. The date of termination of the Plan, or if any dependents' benefit of the Plan is terminated, the date of termination of such dependents' benefits.

In addition, under certain conditions, your Dependent's Medical expense coverage may be continued after the date it would terminate. See the Continuation of Coverage provisions described on page 11 under COBRA provisions.

NOTE: When both Federally and State-required continuation are available to you and/or your Dependents, a choice must be made. Thus, the advantage and disadvantages of Federal vs. State continuation should be carefully weighed before either is chosen.

## **Leaving Covered Employment//Reinstatement of Eligibility**

Upon leaving Covered Employment a person having reserve hours to their credit in the Health and Welfare Plan will have the following options:

1. Running out his or her reserve hours, or
2. Serving notice to the Administrative Office within 30 days of leaving Covered Employment of his or her desire to freeze his or her reserve hours for a period not to exceed one (1) year.
  - A. The freezing of reserve hours will be effective on the first day of the calendar month beginning subsequent to the date of serving said notice, provided said notice is received by the Administrator prior to the 15<sup>th</sup> of the month; if received after the 15<sup>th</sup> of the month, the freezing will become effective on the first day of the second (2<sup>nd</sup>) following calendar month.

Upon re-entry into Covered Employment within the one-year period from the date of serving above notice, a person shall be allowed 30 days within which to file notice of their intention to use their reserve hours.

The notice should be in writing and sent to:

United Administrative Service  
1120 S. Bascom Avenue  
San Jose, CA 95128

## **CONTINUATION OF COVERAGE**

### **Military Service**

Any eligible person who enters the military service or military training under the laws of the United States may elect to have coverage suspended by freezing reserve hours. This request must be made in writing to the Board of Trustees and will be effective the first day of the month following receipt of the request. See address below.

You should notify the Trustees, in writing, as soon as you are aware that you will resume active work by sending a letter to:

United Administrative Service  
1120 S. Bascom Avenue  
San Jose, CA 95128

## **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)**

If you enter full-time military service for a period in excess of 30 days, your coverage will terminate immediately. You may purchase coverage for your dependents under the rules included in the COBRA section described on page 27. You should notify the Administrative Office in the event you enter military service for more than 30 days. However, you may elect to waive your rights under federal law. The months of coverage so applied would no longer be available to provide coverage upon you return to covered employment.

The following procedures are to be followed for employees who are military reservist once called to active duty:

1. Upon notification that an Employee has been called to active duty, an Employee's hours will be frozen from the first day of the month following the date the employee begins active duty. Exception: If the Employee begins active duty on the first of any month, the Employee's hours will be frozen as of the first of that month.
2. The Administrator will notify the Employee of availability to elect continuation of Medical, Dental, Disability, AD&D, Vision, and Life coverage by self-paying the premium to the Administrative Office. Coverage may be continued for a period that is the lesser of 18 months, or a period that ends on the day the individual fails to apply for, or return to a position as an active Employee of San Mateo Electrical Workers.

NOTE: Employees and their dependents may be eligible for coverage under CHAMPUS. The Employees should review these coverages before making a decision to self-pay.

Employees must notify the Administrative Office of his/her return from active duty. The Administrative Office will restore the Employee's frozen hours, and the Employee will once again be eligible for all benefits that he/she would normally have been eligible for had he/she not been called to active duty.

However, you may elect to waive your rights under federal law. In that case, your Reserve Account may be applied to provide coverage for your dependents at the applicable rate for active members. The months of coverage so applied would no longer be available to provide coverage upon your return to covered employment.

### **HMO Enrollees**

If you or your spouse or dependent have USERRA continuation coverage through the Trust's HMO programs and you are terminated from the program because you move out of the

HMO's service area before the applicable USERRA period expires and the Trust does not have a contract with your HMO in that area, you or your spouse or dependent will be allowed to enroll in the Group Medical Plan until the expiration of the applicable USERRA period, so long as payment of USERRA premiums are continuous and timely and the other USERRA requirements are met for the continuation of health coverage. Please call the Administrative Office for additional details.

### **Life, AD&D, Medical and Dental Benefit Continuation**

This plan pays the total cost of the Life, Accidental Death and Dismemberment, Medical and Dental coverages for a person receiving benefits from the Trust for a period of disability for more than 50% of the month; but not to exceed 24 months for any one eligible disability.

Periods of disability are defined as follows:

1. Participant may receive a lifetime maximum of a 24-month benefit for each related period of disability.
2. A disability for an unrelated cause shall be payable only if separated by 12 months after returning to active service and requirements are met for eligibility.

Only one elimination period is required for successive periods of disability, which are considered as one period of disability.

Pregnancy is considered a related disability.

### **CERTIFICATION OF CREDITABLE COVERAGE UNDER HIPAA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this Fund 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 in writing at the following address:

United Administrative Service  
1120 S. Bascom Avenue  
San Jose, CA 95128

You (or someone on your behalf) 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 Fund, acting in a reasonable and prompt fashion, can provide it. If you request, in writing, that the Fund send the certificate to another health plan or issuer and the other plan or issuer agrees, the certificate can be processed by means other than in writing, such as by telephone.

### **Special Enrollment Rights**

There are no special enrollment (or late enrollee) requirements under HIPAA because Employees and/or dependents cannot decline coverage under this Trust and new dependents may be added at any time subject to proof of birth, marriage, etc. One composite employer contribution is paid by the participating employer regardless of whether the employee is single, married, or has dependents.

## **MEDICAL BENEFITS**

This Section highlights the benefits including coverage requirements provided under your plan. The purpose is to give you quick access to the information you will most often want to review. Please read the other sections of this booklet for more detailed explanations of your benefits and any limitations or restrictions that may apply.

### **Coverage Requirements**

A participant must accumulate 600 hours of covered employment in his or her reserve bank to initially become eligible. The charge off for continued eligibility is 120 hours per month. The maximum you can accumulate in your reserve bank is 1200 hours, which is equivalent to 10 months of eligibility. Eligibility is based on a skip month. For example, January hours provide eligibility for March; February hours provide eligibility for April, etc. Refer to pages 5 and 7 for further details.

The number of hours of eligibility for coverage is based on the cost to the Trust for each medical plan.

During open enrollment each year, you may select the Self-Funded PPO Medical Plan or Kaiser as your medical provider. You are allowed to change your medical plan from April 15<sup>th</sup> to May 15<sup>th</sup> by completing a new enrollment card and application for your selected medical provider through the Administrative Office. Your change will be effective June 1st of that year. The booklets covering either Kaiser or the Self-Funded PPO Medical Plan are available at either the Administrative Office or the Local Union Office.

## **Kaiser Participants – Health Maintenance Organization (HMO) Medical Plan**

Kaiser Permanente is a Health Maintenance Organization (HMO) provider. As an HMO participant, you will receive health care services from Plan Providers (physicians, registered nurses, nurse practitioners, and other medical professionals) at Kaiser facilities. Kaiser participants must follow the guidelines below:

- A Health Plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition. The services and supplies must be provided, prescribed, authorized, or directed by a Health Plan physician. You must receive the services and supplies at a Health Plan facility or skilled nursing facility inside our Service Area, except where specifically noted to the contrary in the *Evidence of Coverage Booklet*.
- For details on the benefits and claims review and processing procedures, please refer to the Kaiser's Health Plan *Evidence of Coverage Booklet*.

***For details on your benefits coverage, please refer to Kaiser Foundation Health Plan, Inc., Evidence of Coverage. The Evidence of Coverage is the binding document between the Health Plan and its participants.***

## **Self-Funded PPO Medical Plan**

The Self-Funded PPO Medical Plan allows the option of obtaining treatment from a Prudent Buyer Network Provider (PPO) or a provider who does not participate in the Prudent Buyer Network. All claims, payments, and questions are handled by United Administrative Services (UAS), the claims administrator.

**The plan allows you to seek care from any doctor, medical group, or hospital, but the benefits you receive will be considerably lower if you do not use a Prudent Network Buyer Provider, which means that your out-of-pocket expense will be higher.**

You may access coverage under any one of two levels of coverage, in-network and out-of-network. The applicable deductibles and out-of-pocket amounts will be applied depending which provider you utilize.

You may obtain treatment from any Prudent Buyer Network Provider, participating doctor, or hospital anywhere in California. To you, this means that these doctors and hospitals have agreed to accept the Prudent Network Buyer allowances as full payment for covered services.

### *Coverage*

The PPO Medical Plan includes comprehensive coverage for hospitalization, outpatient treatment, diagnostic laboratory and x-ray services, and prescription medication, as explained

in this Summary Plan Description. You have the option of obtaining treatment from a PPO provider or out-of-network provider.

The plan pays an amount equal to the Prudent Buyer allowance depending upon which provider is utilized for medical treatment received, subject to the deductible and co-payments. Refer to the Schedule of Benefits for deductible, co-payment and maximums.

The Prudent Buyer allowance is the dollar amount paid for each particular type of medical service set by the Prudent Buyer Network. Prudent Buyer Providers have agreed to accept the PPO allowance as full payment for covered services for Prudent Buyer members, although they will often list a higher fee.

Upon your having used \$2,000,000 in lifetime benefits under this plan, the plan will automatically restore an additional \$1,500 on January 1st of each succeeding year.

Any additional limits on the number of visits or days covered are stated under the specific benefit.

#### *Choice of Providers*

The plan covers treatment provided by any physician or surgeon, anywhere in the world, licensed to prescribe and administer all drugs and to perform all surgery deemed necessary by a licensed physician or surgeon.

As a Prudent Buyer member, you will enjoy significant savings by using a Prudent Buyer Network PPO provider. These providers have agreed to accept the Prudent Buyer allowance as payment in full. In utilizing non-Prudent Buyer providers, you will be responsible for any additional charges in excess of the Prudent Buyer allowance.

**Before using a network doctor or hospital, you should always inquire if the Network provider is a Prudent Buyer member.** To verify if your doctor is a Prudent Buyer member, you may contact United Administrative Services at 408-288-4400, or Blue Cross at 1-800-688-3828 or on-line at [www.bluecrossca.com](http://www.bluecrossca.com).

**If your physician refers you to a specialist, you should request a referral to a Prudent Buyer member. This is particularly important for anesthesiologists, radiologists, and for any diagnostic testing.**

#### *Avoid Physician Over-Charges From Prudent Buyer Providers*

Upon visiting a Prudent Buyer Network Provider, the doctor's office will bill for all expenses and payment will be sent directly to the doctor. You will receive an Explanation of Benefits (EOB) form for each claim. This form will show the amount of the claim(s) and how much will be paid to the doctor under the Prudent Buyer Network allowance. The EOB form will tell you how much you pay to the doctor.

Should you receive a bill from a Prudent Buyer Network Provider for more than the Prudent Buyer Network allowance shown on the EOB, you should send the doctor a photocopy of the statement showing the maximum allowance, with a note reminding the doctor he/she is a Prudent Buyer Network member. You are not required to pay any balance exceeding the Prudent Buyer Network allowance when treated by a member PPO doctor. For questions regarding a claim, call United Administrative Services at (408) 288-4400.

### *Summary of Benefit Levels*

When you receive care from a Prudent Buyer Network Provider, you assure yourself of the highest possible benefit. You also save the plan money and help keep medical premiums down, thereby enabling the Trust Fund to maintain a high level of employee health benefits.

**1. Level One - In-Network:** The deductible and the out-of-pocket maximum is the lowest for this level of coverage. If you choose a Prudent Buyer Network Provider to receive services, you will receive the highest level of benefits. Prudent Buyer Network Providers offer a substantial discount, which provides the greatest benefits. **Effective January 1, 2010 there is no deductible per individual and no deductible per family per calendar year. The plan pays 90% of covered expenses until the out of pocket amount reaches \$1,250 for an individual and \$2,500 per family and then 100% thereafter each calendar year.** Physician charges for an office visit require a co-pay amount for each office visit. The office visit co-pay amount does not apply to the annual deductible or the out-of-pocket maximum.

**2. Level Two - Out-of-Network:** This level allows you to seek medical coverage from any medical provider outside of the Prudent Buyer Network, but the benefits you will receive are considerably lower. Your out-of-pocket expense is considerably increased if you choose Level Two benefits. The deductible is \$250 per individual or \$500 per family per calendar year and the plan pays 60% of covered expenses until the out of pocket amount reaches \$2,000 for an individual and \$4,000 per family and then 100% thereafter each calendar year. Physician charges for an office visit require a co-pay amount for each office visit. The office visit co-pay amount does not apply to the annual deductible or the out-of-pocket maximum.

### *Claims Review Procedures*

The following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit made by a Claimant or by an authorized representative of a Claimant, that complies with the Plan's reasonable procedure for making benefit Claims. Communication regarding benefits that is not made in accordance with these procedures will not be treated as a Claim under these Claims Procedures.

Time limits imposed on the Plan are maximum times and begin with the receipt of the Claim without regard to whether the information necessary to make a benefit determination accompanies the filing. In the event that the period of time is extended due to a Claimant's failure to submit information necessary to decide a Claim, the period for making the benefit

determination shall be suspended from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant or his/her authorized representative responds to the request for additional information.

Time limits imposed on the Covered Person are minimum times and may be extended by the Plan. Time limits for furnishing additional information to the Plan begin when the claimant receives the request for additional information.

There are four (4) categories of Claims, each with somewhat different claim and appeal rules based on the type of Claim involved. The primary difference is the timeframe within which Claims and appeals must be determined. It is very important to follow the requirements that apply to your particular type of Claim. If you have any questions regarding what type of Claim and/or what Claims Procedure to follow, contact your Claims Administrator. The definitions of the types of Claims are:

### 1. Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan specifically conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care, unless the Claim involves Urgent Care as that term is described below. Pre-Service Claims are, for example, Claims subject to pre-certification.

In the case of a **Pre-Service Claim**, the following timetable applies:

Notification to Claimant of benefit determination:	30 days
Extension due to matters beyond the control of the Plan:	15 days (Period tolled for Incomplete claims)
Insufficient information on the Claim	Notification of 15 days
Response by Claimant:	45 days Notification, orally or in writing, of failure to follow the 5 days, 24 hours if Plan's procedures for filing a claim
Urgent Care Claim Review of adverse benefit determination:	30 days

### 2. Urgent Care Claim

An Urgent Care Claim is a special type of Pre-Service Claim. A Claim involving Urgent Care is any Pre-Service Claim for medical care or treatment where applying the Pre-Service Claim timeframes described above could seriously jeopardize the life or health of the Claimant; or the ability of the Claimant to regain maximum function; or in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the Claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan and applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving **Urgent Care**, the following timetable applies:

Notification to Claimant of benefit determination:	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to Claimant, orally or in writing	24 hours
Response by Claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours (following response by Claimant)
Review of adverse benefit determination	72 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the Claimant, the attending physician or other authorized representative. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. The Plan shall not terminate or reduce benefits prior to completion of the expedited review.

### 3. Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the Claimant.

In the case of a **Post-Service Claim**, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days (Period tolled for incomplete Claims)
Insufficient information on the Claim	Notification of 15 days
Response by claimant	45 days
Review of adverse benefit determination	60 days

### 4. Concurrent Care Claim

A Concurrent Care Claim is any Claim, including an Urgent Care Claim, approved by the Plan involving an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two (2) types of Concurrent Care Claims: (a) where reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and (b) where an extension is requested beyond the initially-approved period of time or number of treatments.

In the case of a **Concurrent Care Claim**, the following timetable applies:

Reduction of termination prior to end of treatment	72 hours (Urgent Care) 15 days (Pre-Service) 30 days (Post-Service)
Request for extension of treatment (prior to end of Approved treatment)	24 hours
Determination as to extending course of treatment	24 hours (Urgent Care) 15 days (Pre-Service) 30 days (Post-Service)
Review of adverse benefit determination	Reasonable period prior to reduction/termination Standard appeals time frames apply for appeals of extension
Review of adverse benefit determination	72 hours

If there is an adverse determination on a Claim involving Concurrent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant, the attending physician or other authorized representative. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious review. The Plan shall not terminate or reduce benefits prior to completion of the expedited review.

## 5. Notice To Claimant of Adverse Benefit Determinations

Except with Urgent Care Claims, when the notification may be oral, followed by written or electronic notification within three (3) days of the oral notification, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination. A decision on a Claim is "adverse" if it is (a) a denial, reduction, or termination of, or (b) a failure to provide or make payment (in whole or in part) for a Plan benefit. The notice will state the following, in a manner calculated to be understood by the Claimant:

- a. The specific reason or reasons for the adverse determination.
- b. Reference to the specific Plan provisions on which the determination was based.
- c. A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- d. A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the Claimant's right to sue in federal court.

- e. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- f. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the Claimant upon request.
- g. If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
- h. If the adverse benefit determination involves Urgent Care, a description of the expedited review process applicable to such Claims.

***For details on your benefits coverage, please refer to Self-Funded PPO Medical Plan for Active Employees document which is the binding document between the Health Plan and its participants.***

### **DENTAL BENEFITS**

The Trust Fund provides dental care through an insured arrangement with Delta Dental. A separate booklet available at the Administrative Office describes this coverage.

***For details on your benefit coverage, please refer to Delta Dental's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Dental Plan and its participants.***

### **VISION CARE BENEFITS**

The Trust Fund provides vision care benefits through Vision Service Plan. A separate booklet is available at the Administrative Office with complete benefit coverage, limitations, and exclusions.

***For details on your benefit coverage, please refer to Vision Service Plan's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Dental Plan and its participants.***

## **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

When, within ninety days after and as a direct result of an accidental injury, you sustain one of the losses listed below, a dismemberment benefit or the accidental death benefit is paid to you or your beneficiary. This plan is insured by ING.

\$10,000 will be paid if you are under age 70 for loss of

- Life
- Both Hand or Both Feet
- Sight of Both Eyes
- One Hand and One Foot
- One Hand and Sight of One Eye

\$5,000 will be paid if you are age 70 or older

- One-half the benefits show above is paid for loss of
- One Foot and Sight of One Eye
- One Hand or One Foot
- Sight of One Eye

Only one benefit is payable as a result of all losses sustained in any one accident, that is the one for which the greatest benefit is payable.

Loss means, with respect to hands and feet, the actual severance at or above the wrist or ankle joints; with respect eyes, the entire and irrecoverable loss of sight. Limitations: the benefit does not cover loss caused by: war or any act of war; disease or infection (except infection of an accidental wound); suicide or attempt at suicide.

***For details on your benefit coverage, please refer to ING's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Dental Plan and its participants.***

## **HEARING BENEFITS**

A Self-Funded Plan

The Trust will pay a Hearing Benefit, regardless of which medical plan a participant is enrolled in, for the covered hearing benefit charges a Covered Person incurs while otherwise eligible under the Plan. A Covered Person is an Active employee only. Dependents are not eligible for this benefit.

There is no deductible.

### *Percentage Payable*

80% of usual, customary and reasonable charges, known as UCR. The percentage is applied to the covered hearing benefit charges.

### *Hearing Benefit Maximum*

\$500 per ear

### *Covered Hearing Charge:*

A “covered hearing charge” is a charge that meets all of the tests listed below:

1. it is made by a physician or a certified or licensed audiologist for a service or supply that is listed in the Covered Charges List and is furnished to a covered person.
2. It is incurred by a person while covered for the Hearing Benefit. A charge is incurred at the time the service is rendered or the supply is furnished for which the charge is made.

### *Covered Charge Limits:*

The “covered charge limits” that apply to each service or supply are (a) the usual charge for the service or supply; and (b) the customary charge for the service or supply.

### *Covered Charges List:*

The charge for an otologic examination made by a physician, but not for more than one examination during any five-year period.

The charge for an audio logic examination made by a certified or licensed audiologist, and the charge for one follow-up visit.

The charges incurred in connection with the purchase of a hearing aid device (monaural or binaural) prescribed as a result of examinations, but only if the examining physician or

audiologist certifies that he covered person has hearing loss that may be lessened by the use of a hearing aid device. The charges include the charges for:

- a. The actual hearing aid device;
- b. Ear mold(s);
- c. The initial batteries, cords, and other necessary ancillary equipment;
- d. A warranty; and
- e. A follow-up visit within 30 days after the delivery of the hearing aid device.

*Exclusions:*

1. No Hearing Benefit will be paid for the following:
2. Batteries or other ancillary equipment, except those purchased with the hearing aid device;
3. A hearing aid device that exceeds the specifications of the prescription;
4. Service or supply that is not necessary or that does not meet professionally recognized standards.
5. Service or supply that is otherwise covered by the medical plan the participant is enrolled in.

## **EMPLOYEE ASSISTANCE PROGRAM**

### **Alcohol and Chemical Dependency Treatment Program Marital Difficulty, Financial and Life Issues**

The San Mateo IBEW and Beat It! Employee Assistance Program, as part of your health plan benefits, have teamed up to develop an easy to use, confidential benefit to assist you and your eligible dependents with issues such as substance or alcohol abuse, marital difficulty, financial, legal and many other issues.

#### **BENEFIT**

#### *How Do I Get Help?*

You may get advice or assistance by dialing 1 (800) 828-3939 or visit the website at [www.beatiteap.com](http://www.beatiteap.com) to contact an employee assistance professional who will assess your needs and hopefully guide you to a quick resolution or refer you to a treatment specialist.

#### *What about Treatment?*

Beat It! Has an extensive network of carefully selected providers and resources that are knowledgeable, effective and experienced in addressing situations. A full range of treatment facilities, program, counselors and professionals are available to meet your needs.

Services Available Include:

- Acute Inpatient
- Residential Inpatient
- Intensive Outpatient Programs
- Individual Therapy

#### *Professional Referral*

Your selected Medical Plan may provide for certain services covering alcohol and chemical dependency. Please refer to your provider booklet for a more detailed description of coverage.

#### *Is Pre-Authorization Required and What is the Cost?*

All services must be pre-authorized through the Beat It! Employee Assistance Program.

#### *Approved Recovery Facilities*

If you or your eligible spouse uses a Beat It! Approved recovery facility, the Trust will pay up to \$5,000 of eligible charges. The total available for both you and your spouse is \$5,000 (\$2,000 outpatient). Note: you are personally responsible for your share of the cost. You should make your financial arrangements with the recovery facility at the time of your admittance.

#### **WARNING**

You will be responsible for costs in excess of \$5,000. By way of example, some facilities charge approximately \$6,500 for residential treatment. You would have to self-pay \$1,500.

#### *Benefit Limitations*

- If a residential treatment is not completed, either by your choice or by expulsion by the facility for cause, no further payment for another residential or non-residential service will be available until 90 days have elapsed from the date treatment was discontinued.
- If you participate in a covered non-residential program and change to another covered non-residential program, the 90-day waiting period will not apply.

### *Lifetime Maximum Benefit*

For each eligible individual, the Trust will pay up to \$5,000 (total) of eligible charges for residential care and up to \$2,000 for outpatient services. All eligible claims will be paid through United Administrative Services.

## **LIFE INSURANCE BENEFIT**

This benefit is insured by ING.

When the contract administrator receives proof of your death, \$10,000 is paid to your named beneficiary if you are under age 70. One-half that amount is paid if you are 70 years of age or older. You may name anyone you wish, except your employer. If you are currently married and are naming someone other than your spouse as your beneficiary, your spouse must also sign a Beneficiary Designation Card. Our beneficiary designation will be automatically deemed revoked upon certain changes in marital status. If you are currently married and later divorced, your beneficiary designation of your spouse will be deemed revoked unless a Court Order requires you to maintain the beneficiary designation you make.

If you are currently single and later marry, the beneficiary designation you made will be automatically revoked unless the person you named as your beneficiary is the person who becomes your spouse. Should your beneficiary designation be automatically revoked due to either of the foregoing events, benefits will be paid to your estate.

You may also change your beneficiary at any time by filing a written change with the Union office, subject to the spouse consent requirement noted above. When recorded the change will take effect as of the date it was signed provided benefits have not been paid before it was received.

If you name more than one beneficiary:

- But you don't state amounts or order of payment; benefits will be paid equally divided;
- And a beneficiary dies before you – his or her share will be equally divided to the surviving beneficiaries that you had named.

If there is no beneficiary at your death, benefits will be paid to the members of the first surviving class as follows:

- Your spouse
- Your children
- Your parents

- Your brothers and sisters
- Your estate.

Up to \$500 of the benefits may be paid to anyone who pays expenses for your final illness or burial at the discretion of the Board of Trustees. Any payment made in good faith under this provision will discharge Trustee liability to the extent of the payment.

#### *Life Insurance Benefit Extension During Disability*

If you become Totally and Permanently Disabled before age 60, your Life Insurance will be extended for one-year periods during the disability without premium payment. The amount is subject to the same reductions as for non-disabled person.

To qualify, you must:

- Provide approved written proof of Total Disability within 12 months of its start;
- Give proof every 12 months after that;
- Be willing to be examined by a physician as often as is reasonable during the first two years; and, thereafter, no more than once a year.

This extension will end when you

- Stop being disabled;
- Reach age 70;
- Refuse examination;
- Fail to give proof of continued disability.

***For details on your benefit coverage, please refer to ING's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Dental Plan and its participants.***

### **TWO – YEAR DISABILITY**

#### *Eligibility*

A person will become eligible for Disability Benefits if:

Such person was employed in covered employment\* in the electrical construction industry\*\* and he has had continuous coverage under this Plan or the Plan in which apprentices of Local 617 participate, for at least 58 of the 60 months immediately prior to the date of disability and has worked:

- a. 250 hours during the three (3) months immediately preceding disability, including reciprocity hours as defined in (e.) below, or
- b. 500 hours during the six (6) month preceding disability, including reciprocity hours as defined in (e.) below, or
- c. 750 hours during the nine (9) months immediately preceding disability, including reciprocity hours as defined in (e.) below, or
- d. 1000 hours during the twelve (12) months immediately preceding disability including, reciprocity hours as defined in (e.) below.
- e. Exception: When a person works as a Temporary Employee in the jurisdiction of a Participating Trust Fund under the Electrical industry Reciprocal Agreement, such hours may be considered as hours worked as stated above, provided that such hours are reported and paid to this Plan in at least the same amount as required by the I.B.E.W. Local 617, the hours worked shall be prorated and only the prorated number of hours shall be credited as hours worked.

\*For the purpose of eligibility “covered employment” means any month in which a person has been working for a participating employer (one who is signatory to a collective bargaining agreement with I.B.E.W. Local 617), or has made a self-payment.

\*\* The term “electrical construction industry” shall include any public or private employment in a unit represented by I.B.E.W. Local 617 for which contributions are paid or required to be paid to this Trustee for the Disability Plan including work covered as described above in a through d.

#### *Amount of Disability Benefit*

The Disability Benefit consists of a maximum monthly amount of \$650. Benefits will commence on the last day of the month in which the completion of the elimination period below occurs. Benefit payments shall be pro-rated on a daily basis for the month benefits commence and for the month benefits cease. This amount may be changed in the future.

#### *Elimination Period*

A person must be continuously and totally disabled for a period of thirty (30) days before being eligible for paid benefits. Total disability will be deemed to have commenced as of the first visit with a licensed physician or hospital for such disability.

#### *Benefit Payments*

For disabilities, which occur up to age 63, benefits shall cease for the months following attainment of age 65, upon recovery, death, or as provided as the following paragraph below, Whichever shall occur first:

- a. After 24 months of benefits payment, or

- b. Upon recovery, or
- c. Upon death.

Disability payments will be made to persons meeting the qualifications for a period commencing with the last day of the month in which the completion of the elimination period occurs, after commencement of a certified disability and ending upon the date of recovery or as otherwise provided.

Benefits will stop with the month that any beneficiary accepts a benefit payment from the San Mateo County Electrical Industry Retirement Trust.

Benefit payments will stop with the first month that a beneficiary starts to receive regular Social Security benefits (not Social Security Disability benefits).

In no event shall benefit payments, in the aggregate, exceed 24 months for any one related disability.

#### *Definition of a Disability*

A person will be considered "disabled" during the 24 months of disability if unable, solely because of disease or injury, to work as an electrician as determined by the Board of Trustees.

To be considered disabled, a person must be under the care of a licensed physician and cannot be registered on the IBEW Local 617 out-of-work list.

Proof that a person continues to be disabled may be required at reasonable intervals by the Trust. If a person fails to furnish proof or refuses to be examined by a physician (designated and paid for by the Trust), such person will no longer be considered disabled. Disability benefits under the Plan will be suspended for lack of cooperation.

#### *Benefits Improperly Paid*

Any benefit paid to a person not entitled thereto shall be repaid to the Trust. Notwithstanding any other provisions of this Plan, if such improper payments are not repaid to the plan, overpayments shall be deducted from future benefits payable to the recipient.

#### *Periods of Disability*

Periods of disability are defined as follows:

- a. Participant shall receive a lifetime maximum of a 24 monthly benefit for each related period of disability.

- b. A disability for an unrelated cause shall be payable only if separated by 12 months after returning to active service and the qualifying requirements stated under the eligibility section.
- c. Only one elimination period will be required with respect to successive periods of disability, which are considered as one period of disability.
- d. Under the Plan, pregnancy shall be considered as a related disability.

#### *Life, AD&D, Medical and Dental Benefit Continuation*

This Plan shall pay the total cost of the Plan's Life, AD&D, Medical and Dental coverages For a person receiving disability benefits from the Plan for more than 50% of the month, but not to exceed 24 months for any one eligible disability.

#### *Exclusions*

Certain disabilities are beyond the scope of this Disability Benefit Plan. Therefore, a person will not receive benefits for disability arising from any of the following causes:

- Intentional self-inflicted injuries, alcoholism or drug abuse;
- The commission of, or participation in a crime (and no actual conviction is required);
- An act of war, (whether declared or not), insurrection, rebellion or participation in a riot or civil commotion;
- Where such bodily injury or disease is due to such person's willful engagement in any illegal activity or occupation or the self-inflection of such, or any other injury resulting from chronic alcoholism, use of alcohol, or the use of narcotics, unless the same were administered pursuant to the orders of a licensed physician.

#### *Third Party Responsibility*

If an eligible person's disability is caused by an act or omission of a third party, the disabled participant is required to assign his or her claim for reimbursement, indemnification, damages or other redress to the Plan up to the amount of disability benefits paid or payable to the disabled person. As a condition for receipt of benefits under the Plan, any such disabled participant agrees to reimburse the Plan for any recovery from a third party and/or agrees to permit the Plan to intervene or otherwise participate in any lawsuit, arbitration or other proceeding.

**NOTICE TO THOSE ELIGIBLE FOR MEDICARE PART D**

Effective January 1, 2006, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 created a new prescription drug benefit referred to as Medicare Part D Prescription Drug Coverage (Medicare Part D coverage or coverage). The coverage is available to all Medicare eligible employees and/or dependents who are age 65 or older or are disabled and are receiving Social Security disability benefits, and those with end stage renal disease. The enrollment period for Medicare Part D is November 15<sup>th</sup> through December 31<sup>st</sup>.

A notice containing general information about Medicare Part D coverage and this Plan is required to be provided to you (a Medicare eligible individual) by the Trust Fund prior to each annual Medicare Part D enrollment period beginning November 15, 2005. The notice must also be provided to you prior to your initial enrollment period for Medicare Part D coverage, prior to the effective date of your enrollment in this Plan, whenever the Plan's prescription drug coverage ends or changes so that it is no longer creditable, and upon your request. "Prior to" means within 12 months before the event in question.

The Plan intends to continue to provide a prescription drug benefit that is equivalent on a gross basis to Medicare Part D coverage. Therefore, there is no requirement that you enroll in Medicare Part D. The Plan will notify you if this changes.

**COBRA**

<b><i>IF YOUR COVERAGE ENDS BECAUSE OF:</i></b>	<b><i>COVERAGE MAY CONTINUE FOR UP TO:</i></b>
<b>Termination of employment (for any reason other than gross misconduct) or reduction in work hours</b>	<b>18 Calendar Months*</b>  <b>(*29 Calendar Months (18 Calendar Months plus an additional 11 Calendar Months), if employment ends due to termination of employment or reduction in hours, and at any time during the first 60 days of continuation coverage, the Member or his or her Dependent is totally disabled (as determined by Social Security)).</b>
<b>Death of Member</b>  <b>Member's entitlement to health care coverage under Medicare</b>  <b>Legal separation, divorce, cessation of domestic partnership</b>	<b>36 Calendar Months for Dependent</b>

<b><i>IF YOUR COVERAGE ENDS BECAUSE OF:</i></b>	<b><i>COVERAGE MAY CONTINUE FOR UP TO:</i></b>
<b>Dependent Child no longer qualifies for Dependent coverage under the Plan</b>	<b>36 Calendar Months for Dependent</b>

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that the Trust Fund participants (covered employees and dependents) be allowed to continue their medical and dental coverage under the Trust Fund at their own expense following certain qualifying events, which request in a loss of coverage. The premium is 102% of the cost of coverage and administrative expenses.

If your employment terminates or your hours are reduced so that you become ineligible for coverage, you and your eligible dependents may elect COBRA continuation coverage for up to 18 months from the date your coverage would otherwise have ended.

If you or an eligible dependent are determined by Social Security to be disabled within 60 days of the date on which COBRA coverage commenced, the disabled individual is entitled to extend the regular 18-month COBRA continuation coverage to 29 months. Eligible dependents of the individual electing this coverage may also receive additional coverage during this special 11-month extension. The premium for the additional 11 months of extended coverage is 102% of the cost of that coverage.

To be eligible for the special 11-month extension, the disabled individual must notify the Plan within 60 days following the later of the date on which the individual receives the initial COBRA notice following a qualifying event or the date Social Security determines that the individual is disabled and in all events before the end of the initial 18-month period of COBRA continuation coverage.

Children born to you or placed with you for adoption during your continuation coverage are eligible to participate in your COBRA coverage, but there may be an additional premium required for their participation. Should you desire this additional coverage, you must promptly notify the Administrative Office at the time of birth or placement for purposes of adoption.

If you first become entitled to Medicare while on COBRA coverage which was elected following a termination of employment or a reduction in hours, your eligible dependents may elect to extend their initial 18-month COBRA continuation coverage period to 36 months from the date you initially became covered due to a COBRA election.

If your dependents lose coverage due to your death, your surviving spouse and other covered dependents may elect COBRA continuation coverage lasting for up to 36 months from the date their coverage would otherwise have ended.

If a child ceases to be eligible for benefits due to a loss of dependent status, that former dependent may elect COBRA continuation coverage lasting up to 36 months from the date his or her coverage would otherwise have ended.

If your spouse ceases to be an eligible dependent because of a divorce or legal separation, your former spouse may elect COBRA continuation coverage lasting for up to 36 months from the date your spouse's coverage would otherwise have ended.

A parent electing COBRA continuation coverage may elect to continue coverage for dependent children. An employee electing COBRA continuation coverage may elect to continue coverage for the employee's lawful spouse.

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 19<sup>th</sup> through 29<sup>th</sup> months of the extended coverage will be 150% of the cost of that coverage and administrative expenses.

COBRA continuation coverage terminates on the earliest of the following events:

- 1) The last day of the period for which COBRA continuation coverage may be elected;
- 2) The date a required COBRA premium payment is due and not received by the Administrative Office;
- 3) The date the Plan is terminated;
- 4) The date the individual receiving coverage pursuant to COBRA first becomes covered under another group medical plan, which does not contain any exclusion or limitation with respect to any preexisting condition of such person. This date may vary for different employees of the same family;
- 5) The date the person on COBRA continuation coverage first becomes entitled to Medicare coverage. The right to COBRA continuation coverage terminates only for the person who becomes entitled to Medicare coverage;
- 6) For individuals who are receiving the special 11-month extended coverage period due to disability, the first day of the month that begins more than 30 days after such a person is no longer disabled; and
- 7) The expiration of the applicable 18-month, 29-month, or 36-month COBRA continuation period.

If your coverage ends because of the termination of employment or reduction of hours or because of your death, you or your dependents will receive information from the Administrative Office within 60 days of the date of loss of coverage. The Trust Fund will then transmit a notice of COBRA continuation rights and an application related to the coverage.

The materials transmitted by the Plan will explain your available options. The materials transmitted will also explain the application process and the premium rates applicable to coverages elected.

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.

At the end of the COBRA continuation period elected, you may be allowed to enroll in an individual conversion health plan provided to the Plan by certain service providers (such as an HMO or insurance company). Information related to individual conversion health plans may be obtained from the Administrative Office or the specified service provider.

If you or your spouse or dependent have COBRA continuation coverage through one of the Fund's HMO programs and you are terminated from the program because you move out the HMO's service area before the applicable COBRA period expires and the Fund does not have a contract with your HMO in that area, you or your spouse or dependent will be allowed to enroll in the group Medical Plan until the expiration of the applicable COBRA period, so long as payment of COBRA premiums are continuous and timely and the other COBRA requirements are met for the continuation of health coverage. Under no circumstances would such a transfer prolong the period of your COBRA continuation coverage. Please call the Administrative Office for additional details.

In order to assure receipt of COBRA materials and other announcements describing changes in the Plan, you and your dependents should advise the Administrative Office of any and all changes in your address.

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 Administrative 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.

### **FAMILY AND MEDICAL LEAVE ACT**

The federal Family and Medical Leave Act (FMLA) enacted by Congress in 1993 provides that in certain situations certain employers are required to grant leave to employees and that in such situations the employer is required to continue medical coverage for the employees.

Certain employers must continue to pay for your health coverage during any approved leave. In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

- 1) Your employer has at least 50 employees;
- 2) You worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and
- 3) You require leave for one of the following reasons:
  - a) Birth or placement of a child for adoption or foster care;

- b) To care for your child, spouse or parent with a serious medical condition, or
- c) Your own serious health condition. Details concerning FMLA leave are available from your employer.

Requests for FMLA leave must be directed to your employer; the health plan cannot determine whether or not you qualify. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments.

If the dispute is resolved in your favor, the health plan may obtain the FMLA-required contributions from your employer and will refund the corresponding COBRA payments to you.

If your employer continues your coverage during a FMLA leave and you fail to return to work, you may be required to repay the employer for all contributions paid to the Plan for your coverage during this leave.

It is not the role of the Trustees or Trust Fund to determine whether or not an individual employee is entitled to leave with continuing medical care under the applicable laws or the provisions of a collective bargaining agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the employer, employee and, where applicable, the local union.

To the extent that participants are entitled to leave with continuing medical coverage pursuant to federal and state law or provisions contained within collective bargaining agreement, the Trust Fund will provide continuing medical coverage so long as required monthly contributions are received from the contributing employer.

### **RIGHTS OF STATES**

Payment of benefits with respect to a participant shall be made in accordance with any assignment of rights made by or on behalf of such participant or beneficiary of a participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of that Act.

To the extent that payment has been made under a state plan for medical assistance approved under the Title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payments for items or service constituting such assistance, payment for benefits under the Plan shall be made in accordance with any state law which provides that the state has acquired rights with respect to a participant to such payment for such items or services.

## **NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996**

Pursuant to the Newborns' and Mothers' Health Protection Act of 1996, the Medical Plans in which you may enroll may not restrict benefits for any hospital length of stay for the mother or newborn child to less than 48 hours following normal delivery or less than 96 hours following a cesarean section delivery.

In accord with Federal Law, those Plans do not require that a provider obtain preauthorization under those Plans for either of the foregoing lengths of stay. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than the applicable time period.

## **WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998**

Your Plan covers medical and surgical benefits for mastectomies. This coverage includes:

- 1) Reconstruction of the breast on which the mastectomy was performed;
- 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance;  
or
- 3) Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

The coverage is subject to the Plan's annual deductibles and coinsurance provisions.

## **PRIVACY OF PROTECTED HEALTH INFORMATION UNDER HIPAA**

This 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. When held by this Plan, it also means information that either identifies you or your eligible dependents directly or indirectly, in that one has a reasonable belief that you or your eligible dependents can be identified using the information. For example, your name, address, birth date, marital status, Social Security Number, and choice of health plan would be considered PHI. Other examples are the amount of contributions paid by your employer for your coverage, or whether you are an active employee, retiree, or Medicare enrollee.

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

### **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.

### **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.

### **Agreed to Uses and Disclosures of PHI by You After an Opportunity to Agree or Disagree to the Use or 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.

### **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 Administrative Office.

## **Your Individual Rights**

HIPAA and the Privacy Rule afford you the following rights:

- 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.
- 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.
- 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.

- 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.
- 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.

### **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.

### **This Plan's Duties**

In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The Administrative Office has designated this group of employees to include Mail Clerks, Eligibility Certifiers, Supervisors and Managers. 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.

### **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 its 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.

### **The Board of Trustee's Duties**

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have amended this Plan's Trust Agreement and 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. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement, Notice of Privacy Practices For Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Administrative Office.

### **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:

Jean Sukovez  
United Administrative Services, Inc.  
1120 Bascom Avenue  
San Jose, CA 95128  
Phone (408) 288-4400

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.

### **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 agents, 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.

## **RECIPROCITY AGREEMENTS**

This Trust Fund participates in the national reciprocity plan with certain other trust funds. If you elect to send your earned contributions to another Trust Fund through reciprocity, you will not be eligible under this Plan. Contact the Administrative Office if you have a question regarding reciprocity.

An election to direct your contributions to another Plan will act as a release and waiver of any and all claims against the Plan.

If the contribution rate of the Home Fund to which your contributions are transferred is less than the contribution rate of this Plan, the Home Fund amount will be transferred, and the contributions over and above that hourly rate (excess contributions) will be retained by his Plan. By election reciprocity, you waive any claim that might otherwise be made based on the retention by this Plan of these excess contributions.

## **ACTS OF THIRD PARTIES**

If an Employee (including an eligible dependent) is injured through the act or omission of another party, Plan benefits are provided only on the following conditions:

- 1) The Employee or dependent will be required to pay to the Plan or any entity providing benefits (such as Kaiser or Blue Shield) immediately any proceeds received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance) arising out of any claims for damages by the individual or his or her heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the third party may be responsible;
- 2) Any Employee or dependent who accepts payments from the Plan agrees that by doing so he or she is making a present assignment of his or her rights against such third party to the extent the payments made by the Plan. These rules are automatic, but the Plan may require that any participant or dependent sign an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require; and
- 3) Any Employee or dependent who refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. Any employee or dependent who receives benefit payments and later fails to reimburse the Plan as set forth above will be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the employee or dependent has failed to reimburse, including reasonable interest on such unpaid funds.

By accepting benefit payments from the Plan, any Employee or dependent agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the employee's own carrier for uninsured motorist's coverage. A lien shall exist in favor of the Plan upon all sums of money recovered by the Employee or dependent against the third party. The lien may be filed with the third party, the third party's agents, or the court. The employee or dependent shall do nothing to prejudice the Plan's right as described above without the Plan's written consent.

If the Employee or dependent settles or compromises a third party liability claim in such a manner that the plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the employee or dependent shall receive no further benefits from the Trust Fund in connection with the medical condition forming the basis of the third party liability claim unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Trust Fund.

### **COORDINATION OF BENEFITS**

General Coordination of Benefits Rule: If a covered employee or dependent is entitled to benefits from another plan, the HMOs, insurance companies or other entities likely have rules on which plan is primary or secondary and who pay first. You should consult with these entities to determine the rule. The benefits provided herein shall be paid in accordance with the standardized coordination of benefits provisions of the National Association of Insurance Commissioners.

### **BENEFIT CONTINUATION** (Amendment and Termination)

It is the intent of the Trustees to continue this plan indefinitely, although they reserve the right to modify or discontinue this coverage at any time. Thus, benefits may be reduced or eliminated entirely. Moreover, participants could be asked to pay a portion or all of the required premium.

### **EXCLUSION FOR FRAUD**

No benefits are paid for fraudulent claims or services or supplies by a covered Employee, eligible dependent or any other person. If a fraudulent claim has been paid by the Plan or by any entity on behalf of the Plan for any person, both the Employee and any person on whose behalf a fraudulent claim was submitted or paid is liable to the Plan for repayment of benefits paid and the amount of any premium paid to an HMO, PPO, insurance company or any other entity. This does not preclude the Plan, HMO, PPO, insurance company or other entity from bringing a lawsuit against any person who commits fraud to recover improperly paid benefits,

services or supplies, including reimbursement for any attorney's fees and costs incurred to recover such amounts.

By way of example, if an Employee improperly signs up a person as a dependent who is not lawfully a dependent under the Plan, both the Employee and such unlawful dependent will be liable to the Plan and the Plan's providers for any claims paid, any premium paid by the Plan, and any attorneys fees and costs incurred by the Plan and any provider in recovering such improperly paid claims.

## **APPEAL PROCEDURE**

### *Health Plan*

Copies of the applicable appeals procedures are available from the pertinent insurance companies or other providers. The Plan's Self-Funded PPO Medical Plan and Kaiser have their own appeal procedures set forth in their applicable documents.

It is required that your Health Plan provide you with specific reasons for denial of benefits and that you be given the opportunity for "full and fair review" of the denial from the provider of service (carrier).

- 1) The denial notice must include the following:
- 2) The specific reason(s) for the denial;
- 3) The specific reference to pertinent plan provisions on which a denial is based;
- 4) A description of any additional material or information is necessary for you to make your claim, and an explanation of why such material or information is necessary, and
- 5) Information on the steps to be taken if you wish to submit your claim for review.

You have at least 180 days (or longer if your plan agrees) to submit our claim for review.

A decision must be made on your initial request for a plan benefit as follows:

- 1) Claims for urgently needed care must be ruled on "as soon as possible", and in no event more than 72 hours after the claim is filed;
- 2) Claims for pre-approval benefits must be decided upon within 15 days; and
- 3) Claims for reimbursement when you have already received care must be ruled on within 30 days.

## *Disability Plan*

Decisions on disability claims and appeals have different time periods. If the Plan denies your application for disability benefits, the Plan will notify you of the denial within 45 days after the Plan's receipt of your application or claim.

An extension of time no exceeding 30 days may be necessary due to matters beyond the Plan's control. If a decision cannot be rendered due to matters beyond the control of the Plan prior to the expiration of the 30 day extension, the period for making a determination may be extended for up to an additional 30 days, in which event notice will be sent to you prior to the expiration of the first 30 day extension.

The notice of extension will include in addition to the information set forth above, the standards on which entitlement to a benefit is based; the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days to provide the specified information, if any. The deadline for the Board of Trustees to render its decision is tolled from the date on which the notification of the extension is sent to you until the date a response from you is received.

The denial notice of a disability claim should include the same information as that set forth above pertaining to non-disabled claims.

## *Appeal*

If the application for benefits or a claim is denied, you or your authorized representative may petition the Board of Trustees for review of the decision (an appeal). Your appeal must be filed with the Plan within 180 days of your receipt of the denial notification. You may have access to relevant documents, records and other information, including any statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Your appeal of the adverse benefit determination of your disability claim will be decided at the next regularly scheduled meeting the Plan's Board of Trustees following the Plan's receipt of your appeal, unless the appeal was received within 30 days of the Board meeting. If that occurs, the appeal must be decided by the following regularly scheduled Board meeting.

## *Finality of Decision on Claim – Right to File Lawsuit*

The denial of an application or claim after the right to review has been waived or the decision of the Trustees on appeal has been issued is final and binding upon all parties, including the claimant.

No lawsuit may be filed without first exhausting the above appeals procedure. No legal action may be commenced or maintained against the Plan or any Trustee or legal fiduciary, person or entity involved in the decision more than two years after a claim has been denied on appeal.

### **GENERAL PROVISIONS**

The benefits payable hereunder shall not be subject to any manner of anticipations, alienation, sale or transfer.

Self-funded plan benefits shall be paid only if notice of a claim is made within 90 days from the date on which covered charges were incurred. The claimant must submit properly completed claim forms and itemized statements as authorized by the Board of Trustees. Any exceptions to the submission of the claims later than 90 days are subject to the approval of the Board of Trustees, but in no event may claims be considered for payment later than 15 months from the date on which covered charges were incurred.

In the event the Plan determines that the Covered Person is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Covered Person has not provided the Plan with an address at which they can be located for payment, the Plan may, during the lifetime of the Covered Person pay any amount otherwise payable to the Covered Person, to the spouse, or relative by blood of the Covered Person, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Covered Person before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Covered Person: Lawful spouse, child or children, mother, father, brothers or sisters, or to the Covered Person's estate, as the Board of Trustees, in its sole discretion, may designate. Any payment in accordance with the provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

No employee, dependent or other beneficiary shall have any right to claim to benefits from the Plan, except as specified. Any dispute as to eligibility, type, amount or duration of the benefits under this Plan or any amendment or modification thereof shall be resolved by the Board of Trustees. The Trustees shall have discretion in any such determination. Participants may seek review of any adverse decision of the Trustees in Federal District Court as prescribed by law.

The benefits provided by the Plan are not in lieu of and do not affect any requirement for covered by Workers' Compensation Insurance laws or similar legislation.

The provisions of the Plan are subject to and controlled by the provisions of the Trust Agreement, if applicable, and in the event of any conflict between the provisions of the Trust Agreement and the provisions of this Plan, the Trust Agreement shall prevail. Certain benefits are self-funded and any references to "insurance" are inapplicable to Self-Funded benefits.

It is recognized that the self-funded benefits provided by the Plan can be paid only to the extent that the Fund has available adequate resources for such payment. No contributing employer, the Local Union nor any individual trustee or the Board of Trustees has any liability, directly or indirectly to provide the self-funded benefits established hereunder beyond the assets available in the Fund and the obligation of contributing employers to make contributions as stipulated in the collective bargaining unit agreements.

**WARNING: BENEFITS CAN BE REDUCED OR ELIMINATED.**

The Board of Trustees reserve the right to reduce or modify any and all benefits of the Plan, in part or in whole, and may change or eliminate any or all insurance carriers, HMOs and any other provider or entity. The Board may also require contributions for any increases to the Plan from time to time from the Participants of the Plan. Any such changes are at the discretion of the Board of Trustees.

**GENERAL INFORMATION**

(As Required by ERISA)

1. **Name and Address of the Plan:** San Mateo Electrical Workers Health Care Benefits Plan, 1120 South Bascom Avenue, San Jose, California 95128.
2. **Type of Plan:** This is a Health Care Plan, providing the following Health Care Benefits Plan –Hospital, Surgical, Medical, Dental, Vision, Hearing, Disability, Life, AD&D and Employee Assistance Program coverages.
3. **Type of Administration and Method of Fund Benefits:** This Plan is administered by the Joint Board of Trustees. The Plan is funded by employer contributions as provided for in the collective bargaining agreement. Claims not related to HMO and insured providers are processed by a contract administrator.
4. **Sponsoring Organizations:** The Plan is maintained in accordance with collective bargaining agreements between N.E.C.A., San Mateo Chapter and Local 617 of the International Brotherhood of Electrical Workers Union. By writing to the Union, participants and beneficiaries may determine whether a particular employer is a sponsor of the Plan, and if so, the employer’s address.
5. **Contributions:** Contributions to provide Plan benefits are paid by the sponsoring employers in accordance with their bargaining agreements “on a cents-per-hour basis”.
6. **Appeal Procedure:** The procedure for file appealing denials are set forth on page 44 and in the separate booklets furnished by the insurance companies and other entities.
7. **Fiscal Year:** The fiscal year of the Trust is the twelve-month period ending each January 31<sup>st</sup>, and the Trust’s records are maintained on that basis.

8. **Employer Identification Number:** 94-6077920

9. **Plan Number:** 501

10. **ERISA Rights:** As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office 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.
- 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 of some of these documents.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report at no cost to the participant.
- Continued health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as the result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description on the rules governing your COBRA continuation coverage rights.

To the extent that this Plan has any exclusionary periods of coverage of pre-existing conditions reduction or elimination of those exclusionary periods 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 as follows:

- when you leave coverage under that Plan, when you become entitled to elect COBRA continuation coverage;
- when your COBRA continuation coverage ceases;
- if you request it before losing coverage; or
- upon your request up to 24 months after losing coverage.

You may be subject to any pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the Employee Benefit Plan. The individuals who

operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interests 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 benefits under the plan or exercising your rights under ERISA. If your claim for benefits is denied in whole or in part, you must receive a written explanation for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA there are steps you can take to enforce the above rights.

For instance, if you request materials from the Plan and do not receive them within 20 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 \$110.00 per 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, which 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 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 the 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, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

#### **11. Names and Addresses of the Board of Trustees:**

Employer Trustees:

Mr. Patrick D'Antoni  
NECA  
1900 El Camino Real  
Menlo Park, CA 94025

Mr. James E. Goetz  
NECA  
1900 El Camino Real  
Menlo Park, CA 94025

Mr. Dennis Agresti  
NECA  
1900 El Camino Real  
Menlo Park, CA 9402

Union Trustees:

Mr. Dominic Nolan  
IBEW Local 617  
1701 Leslie Street  
San Mateo, CA 94402

Mr. Mark Leach  
IBEW Local 617  
1701 Leslie Street  
San Mateo, CA 94402

Mr. Matt Hollister  
IBEW Local 617  
1701 Leslie Street  
San Mateo, CA 94402

**12. Name and Address of Contract Administrator:**

United Administrative Services, Inc.  
1120 Bascom Avenue  
San Jose, CA 95128  
Phone (408) 288-4400

**13. Name and Address of Agent for Service of Legal Process:**

Neyhart, Anderson, Freitas, Flynn & Grosboll  
Attorneys at Law  
44 Montgomery Street  
Suite 2080  
San Francisco, CA 94104-6702  
Telephone: (415) 677-9440

**HIPAA**

In accordance with the new disclosure requirements of the Health Insurance Portability and Accountability Act, we are informing you of the names and addresses of all Health Providers for the Trust Fund and their roles (i.e., whether they guarantee the payment of benefits or provide administrative services).

**List of Providers**

United Administrative Services Inc.  
1120 Bascom Avenue  
San Jose, CA 95128  
Phone: (408) 288-4855

Administers the self-funded plans; hearing and the alcohol/chemical dependency plans. Does not guarantee payment of benefits.

Beat It!

1796 Technology Drive  
San Jose, CA 95110

Provides Employee Assistance with substance or alcohol abuse, marital difficulty, financial, legal and other issues. Does not guarantee payment of these benefits.

Delta Dental

100 First Street  
San Francisco, CA 94105

Provides prepaid dental benefits with guaranteed payment of these benefits.

Kaiser Foundation Health Plan

1800 Harrison Street, 13<sup>th</sup> Floor  
Oakland, CA 94120

Provides prepaid medical benefits with guaranteed payment of these benefits.

ING

6140 Stoneridge Mall Road, Suite 150  
Pleasanton, CA 94588

Fully insures life and accidental death and dismemberment benefits for eligible participants.

Vision Service Plan  
333 Quality Drive  
Rancho Cordova, CA 95670  
Phone: 1-800-877-7195

Administers the self-funded vision plan for participants and dependents.

The Act also requires that we inform you of the Department of Labor address in Washington, D.C. If you have any questions about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. Additional information regarding your ERISA rights may be found in your Summary of Benefits booklet under "Statement of ERISA Rights".