

**SAN MATEO COUNTY ELECTRICAL WORKERS
HEALTH CARE PLAN**

**EVIDENCE OF COVERAGE
FOR ACTIVE EMPLOYEES**

**SELF FUNDED BENEFIT PLANS
PPO MEDICAL PLAN
PRESCRIPTION PLAN**

**EMPLOYEE ASSISTANCE PLAN
HEARING BENEFIT PLAN**

FOR MEMBERS OF IBEW LOCAL 617

**July 2008
Updated January 1, 2010**

Keep this booklet for future reference.

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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 or require another 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.

Forward

July, 2008

Dear Participant:

This booklet known as a Summary Plan Description for the PPO Medical Plan has general information for the Self Funded Medical Benefits. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please consult the Trust Fund's Summary Plan Description for all provisions regarding eligibility, reserve bank, and termination of coverage. Please direct any questions you have to the Administrative Office at (408) 288-4400.

Please remember that this booklet's only a summary. In the event of any dispute, the official language of the Trust Fund Plan Document will be in control. Refer to the San Mateo County Electrical Workers Health Care Plan Summary Plan Description.

Only the full Board of Trustees is authorized to interpret the Plan. The Board has the discretionary authority to decide all questions about the Plan, including questions about your eligibility for benefits, the amount of any benefits payable to you, and the interpretation of the Plan. No individual Trustee, Employer or Union Representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board. The Board also has discretion to make any factual determinations concerning your claim.

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. 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, in May, at which time you may elect to change your benefit plan options selection by completing a new enrollment card through the Administrative Office. 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.

The Board of Trustees

IMPORTANT NOTICES:

FUTURE PLAN AMENDMENTS

Future amendments to the Plan may be made from time to time to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Trustees. Before you decide to retire, you may want to contact the Trust Fund Office to determine if there have been Plan amendments or other developments that may affect your retirement plans.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS

This booklet, known as the Plan's Evidence of Coverage for Active Employees should be used in connection with the San Mateo Electrical Workers Local 617 Formal Summary Plan Description. This booklet provides a brief, general summary of Self Funded Plan benefits and rules. You should review the Formal Summary Plan Description to fully determine your rights, including the Plan's eligibility rules.

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

If you would like an interpretation of the Plan, you should address your request in writing to the Board of Trustees at the Trust Fund Office. **To make their decision, the Trustees must be provided with full and accurate information concerning your situation. You should also ensure that you provide accurate facts in all forms and documents submitted to ensure you are not held liable for coverage of ineligible Dependents and/or claims.**

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

NO VESTED RIGHTS

Benefits under this Plan are NOT vested. The Board of Trustees may amend, reduce, eliminate or otherwise change the Plan at any time and may change, reduce, or discontinue any Plan benefits, in whole or in part, at any time. Moreover, the Board of Trustees may require new or greater co-payment at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.

USE OF MASCULINE GENDER WORDS

In all situations, whenever any words are used in the Plan in the masculine gender, they should be construed as though they were also used in the feminine gender where they would so apply.

I. ELIGIBILITY REQUIREMENTS, RESERVE BANK ACCOUNT, TERMINATION OF COVERAGE, MILITARY SERVICE RULES

Refer to the San Mateo County Electrical Workers Health Plan's Summary Plan Description for:

- A. Eligibility definitions and rules.
- B. Reserve Bank Information
- C. Military Service Rules

IMPORTANT NOTICE: WARNING ABOUT FRAUD AGAINST PLAN

It is the Participant's and Dependent's responsibility to notify the Trust Fund Office immediately when a Dependent's status changes. This includes divorce/final dissolution of marriage, legal separation, death, a Dependent child over 19 who is no longer enrolled as a full-time student, a child over 19 being employed with health coverage, and any other events which would make your Dependent not eligible for future coverage. If claims are paid for, or premiums are paid on behalf of any Dependent and it is later found that the Dependent was not eligible, you and the Dependent will be responsible for reimbursing the Plan for the actual amount paid out in benefits by the Trust plus interest and any costs and attorney's fees incurred to recover the money.

II. MEDICAL BENEFITS

A SELF-FUNDED PLAN

This Section highlights the benefits including coverage requirements provided under your Self Funded PPO Medical Plan. The purpose is to give you quick access to the information you will most often want to review. Please read the Summary Plan Description of the San Mateo Electrical Workers Local 617 for more detailed explanations of eligibility rules and other provisions and any limitations or restrictions that may apply to this plan.

The 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. This Plan is effective July 1, 2008.

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.

A. 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 (Non PPO) Provider.

1. Level One – In-Network PPO 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.

2. Level Two - Out-of-Network, Non PPO Provider:

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. The amount allowed for Non PPO Providers is based on the Usual, Customary and Reasonable (UCR) Charge. (Please see Definitions in Section II, G) The out of network provider will be reimbursed at 60% of UCR. You will be responsible for any amount the provider charges which is in excess of UCR.

Upon your having used \$2,000,000 in lifetime benefits (per eligible person), 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.

B. 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.anthem.com/ca/

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.

C. 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, or bills you receive from a provider that are in excess of the Prudent Buyer Network Fee, call United Administrative Services at (408) 288-4400.

D. 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 or no deductible per family per calendar year and 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 at the UCR eligible fee 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.

SCHEDULE OF BENEFITS

	LEVEL ONE	LEVEL TWO
	PPO PROVIDERS	OUT OF NETWORK
Deductible Individual	\$0 eff. 1-1-2010	\$250
Deductible Family	\$0 eff. 1-1-2010	\$500
Annual Out-of-Pocket Maximum	The out of pocket maximum is \$1,250 per individual and \$2,500 per family. Deductible and office visit copayments do not apply to the out of pocket maximum. *	The out of pocket maximum is \$2,000 per individual and \$4,000 per family. Deductible and office visit copayments do not apply to the out of pocket maximum. *
LIFETIME MAXIMUM	\$2,000,000 per individual	\$2,000,000 per individual
	BENEFITS FOR COVERED SERVICES	BENEFITS FOR COVERED SERVICES
Physician Services		
Office visits	\$15 COPAYMENT	\$15 COPAYMENT
Hospital/Skilled Nursing visits	90%	60%
Specialists	\$15 COPAYMENT	\$15 COPAYMENT
Surgeon/Asst. Surgeon	90%	60%
Anesthesiologist	90%	60%
Diagnostic X-ray & Labs	90%	60%
Preventative Care		
Routine Physical Exam	90%, up to \$200 annual maximum	60%, up to \$200 annual maximum
Well Baby Care	90%, Covered from birth to age 3	60%, Covered from birth to age 3
Immunizations	90%, Covered from birth to age 3	60%, Covered from birth to age 3
Hospital/Surgical Services		
Inpatient***	90%	60%
Outpatient	90%	60%
Emergency Services		
Ambulance	90%	90%
Emergency Room	90% after \$50 copay, Waived if Admitted	60% after \$50 copay, Waived of admitted

*** Note: Precertification of services is required for non-emergency hospital admissions.

SCHEDULE OF BENEFITS

	BENEFITS FOR COVERED SERVICES	BENEFITS FOR COVERED SERVICES
Maternity Services:		
Hospital Benefits – Delivery***	90%	60%
Outpatient Physician Services	90%	60%
Surgical Services	90%	60%
Mental and Nervous	See Section II, G. Definitions Severe Mental Disorders are not subject to the day or visit limitation.	See Section II, G. Definitions Severe Mental Disorders are not subject to the day or visit limitation.
Hospital Benefits – ***	90%, max 30 days per calendar year	60%, max 30 days per calendar year
Outpatient Physician Services	90%**	60% **
Chiropractic Services and Acupuncture Services	90%**	60%**
Continued Care Services		
Home Health Care	90%**	60%**
Skilled Nursing Facility	Following discharge from an acute care facility, plan pays 90%.	Following discharge from an acute care facility, plan pays 60%.
Physical Therapy	90%**	60%**
Speech Therapy	90%**	60%**
Prescription Drugs-	Refer to Section III, Prescription Drug Benefits For Plan Information	Refer to Section III, Prescription Drug Benefits For Plan Information
Substance Abuse Treatment	Refer to Section IV Employee Assistance Program For Plan Information	Refer to Section IV Employee Assistance Program For Plan Information

** **Note: There is a 30 visit per member, per calendar year limit for these services. Please refer to Section II, G. Definitions, #17, B. for a list of licensed providers.**

*** **Note: Precertification of services is required for non-emergency hospital admissions.**

E. MEDICALLY NECESSARY STANDARDS

The PPO Medical Plan provides that treatment or service must be medically necessary and be covered by your program. United Administrative Services has responsibility for determining whether claims are payable. A practicing physician-consultant retained by the claims administrator must agree if the denial is based on lack of medical necessity. To be considered medically necessary the treatment must be one that cannot be avoided without adversely affecting the patient's condition. The mere fact that your doctor orders the treatment does not mean that it is medically necessary.

Medical Necessity also applies to the type of facility in which you receive care. The Plan does not consider hospitalization medically necessary if the care could be adequately provided in a less expensive facility such as skilled nursing facility or outpatient clinic.

No benefits are payable for care, treatment, services and supplies to the extent that they are not reasonably necessary for treatment of an injury or disease or to the extent that the charges for care, treatment, services or supplies are unreasonable.

F. CLAIMS REVIEW PROCEDURE

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 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.

6. Appeals

Except for Urgent Care Claims, discussed below, an appeal of an adverse benefit determination is considered filed when a Claimant, or an authorized representative, submits a written request for review to:

Plan Administrator
United Administrative Services
P.O. Box 5057
San Jose, California 95150-5057

A request for review will be treated as received by the Plan (a) on the date it is deposited in the U.S. Mail for first-class delivery in a properly-stamped envelope containing the above name and address. The postmark on any such envelope will be proof of the date of mailing.

The Claimant must file an appeal of an adverse benefit determination within 180 days following the Claimant's receipt of the notification of adverse benefit determination, except that the appeal of a decision by the Plan to reduce or terminate an initially-approved course of treatment (see the definitions of a Concurrent Care Claim), the Claimant must submit an appeal within thirty (30) days of the Claimant's receipt of the notification of the Plan's decision to reduce or terminate.

If the appeal involves an Urgent Care Claim, the Claimant or an authorized representative may file a request for expedited appeal orally or in writing. All necessary information for appeal of an Urgent Care Claim denial may be transmitted by telephone, facsimile or other available similarly expeditious method. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan as outlined above. This timing is without regard to whether all the necessary information accompanies the filing.

A Claimant may submit written comments, documents, records, and other information relating to the Claim. A document, record, or other information shall be considered relevant to a Claim if it:

- a. was relied upon in making the benefit determination;
- b. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- c. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- d. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional. The health care professional engaged to review an appeal should be an individual who was neither the person consulted in connection with the adverse determination nor the subordinate of any such individual. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified, without regard to whether the advice was relied upon in making the benefit determination.

The Plan's decision on review is the plan's final decision, subject to a Claimant's option to elect to submit a benefit dispute to the voluntary level of appeal through arbitration described below.

A Claimant has the right to bring a civil action if the Claimant has filed an appeal and the Claimant's request for coverage or benefits is denied following review and/or voluntary arbitration.

7. TWO YEARS TO FILE A LAWSUIT

If your appeal has been denied or there has been a different form of adverse action taken against you, you have two years from the date of such denied appeal or adverse action to file a lawsuit. If you fail to do so, no lawsuit is permitted.

8. PRESCRIPTION DRUG COVERAGE

Questions about your prescription drug coverage. If you have outpatient prescription drug coverage and you have questions or concerns, you may call US-Rx Care at 1-800-248-1062. If you are dissatisfied with the resolution of your inquiry and want to file an appeal, you may write to us and follow the formal appeal process as stated above in Section II, Medical Claims, F. Claims Review Procedure, 6. Appeals.

G. DEFINITIONS

1. **Prudent Buyer Providers (PPO)** is an organization that operates under contract with the Administrator to provide hospital, medical and surgical services at agreed upon allowances. Prudent Buyer providers are located in California.
2. **Prudent Buyer Allowances** is the dollar amount allowed for each particular type of medical service by Prudent Buyer Providers. Prudent Buyer providers have agreed to accept the allowance as full payment for service for Self Funded PPO Plan members, although they will often list a higher fee.
3. **Usual Customary and Reasonable (UCR)** means:
 - a. For providers who are Participants in the Plan's Preferred Provider Organization ("PPO"), UCR means the agreed Prudent Buyer Allowance for the service or supply.

- b. For other non-PPO providers, UCR means the table of covered fees provided by Ingenix in effect at the time of the claim, but in no event shall any amount be paid unless;
 - 1. It is within the range of fees which are usually charged and received for the given treatment by doctors of similar training within the appropriate geographic area;
 - 2. It is customarily charged by the provider for the services or supplies rendered, or if higher than the customary fee, it is justifiable due to a level of treatment which is superior to that customarily provided; and
 - 3. It is reasonable in light of all circumstances.
- 4. The **Employee** is the person enrolled according to the eligibility stated in this plan.
- 5. The **Spouse** is the employee's spouse under a legally valid marriage.
- 6. **Domestic Partner.** California law and this Plan do not recognize common law marriage; however, the Plan does cover certain domestic partners (that live together on a regular basis). A Covered Employee's domestic partner will be covered provided the domestic partnership meets the criteria stated in the Summary Plan Description.
- 7. **Dependent Child** shall be:
 - A. Blood Descendent: A blood descendent of the first degree;
 - B. Adopted Child: 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;
 - C. Stepchild: A stepchild residing in the employee's household;
 - D. Related Child or Children: 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;
 - E. Adding Dependents: 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;

- F. Age Limit for Children/Students: Covered Dependents are eligible for benefits provided from birth until their 19th birthday, 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; and
- G. Student Breaks (Summer Months and Periods of Vacation):

1. Summer Months: During the Summer months (i.e. quarter/semester), coverage will be extended provided the Dependent child continues to meet all Plan eligibility requirements, was a Full-Time student the semester/quarter immediately preceding the Summer break and has enrolled or intends to enroll as a Full-Time student the quarter/semester immediately following the Summer months.
2. Periods of Vacation: A Period of Vacation from Full-Time enrollment does not necessarily terminate a Dependent child's coverage and a Dependent child might qualify for coverage during a period of vacation from full-time enrollment. A period of vacation is defined as one quarter/semester in which a Dependent child is enrolled in less than 9 units of study. In order to qualify for coverage during a Period of Vacation from Full-time enrollment a Dependent child must meet ALL of the following:
 - (a) The Dependent child must meet all other Dependent eligibility requirements and the Participant would be required to sign a statement under penalty of perjury to this effect; and
 - (b) The Dependent child must have been enrolled on a Full-Time basis the semester/quarter immediately preceding this period of vacation (excluding Summer break); and
 - (c) The Dependent child must intend on again enrolling on a Full-Time basis the quarter/semester immediately proceeding this period of vacation (excluding summer months).

Please be aware that if a Dependent child fails to meet all other plan qualifications for Dependent children during a period of vacation, was not enrolled on a full-time basis the semester/quarter immediately preceding the period of vacation, or does not intend on enrolling on a Full-Time basis immediately after this period of vacation, the Dependent child would not qualify for coverage during this break from full-time enrollment; and

- H. Disabled Children: A dependent child also includes a child after his 19th birthday provided the child is both incapable of self-sustaining employment by reasons of mental or physical disability; and chiefly dependent upon you for support and

maintenance. Such qualifications will continue coverage for the child beyond his 19th birthday, up to age 25.

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

8. A **Family Member** is the employee's enrolled spouse or domestic partner and each enrolled eligible child.
9. A **Member** is the employee or family member.
10. The **Agreement Date** is the date this plan comes into effect.
11. The **Effective Date** is the date the member's coverage under this plan begins.
12. **Medically Necessary** services or supplies are those which meet all of the following criteria, as determined by the plan administrator:
 - a. Appropriate and necessary for the symptoms and diagnosis or treatment of a medical condition covered by the plan, and
 - b. Provided for the diagnosis or direct care and treatment of the medical condition, and
 - c. Within the standard of good medical practice within the organized Medical community, and
 - d. Not primarily for the convenience of the member, the member's physician, or another provider, and
 - e. The most cost effective, adequate and safe level of service or supplies which can appropriately be provided. For hospital stays, this means that acute care as a bed patient is needed due to the kind of services the member is receiving or the severity of the member's condition, and that safe and adequate care cannot be received as an outpatient or in less intensified medical setting.
13. A **Hospital** is a facility, which provides diagnosis, treatment and care of persons who need acute care inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Hospitals.

14. An **Outpatient Surgical Center** is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Hospitals.
15. A **Skilled Nursing Facility** is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.
16. **Home Health Agencies and Visiting Nurse Associations** are home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the member's home. They must be recognized as home care providers under Medicare.
17. A **Physician or Surgeon** means
 - A. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided, or
 - B. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this agreement, and when benefits would be payable if the services were provided by a physician as defined in A. above:
 - 1) A dentist (D.D.S.)
 - 2) A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - 3) A certified acupuncturist (C.A.)
 - 4) A chiropractor (D.C.)
 - 5) A physical therapist (P.T. or R.P.T)*
 - 6) A speech pathologist*
 - 7) An audiologist
 - 8) An occupational therapist (O.T.R.)*
 - 9) A psychologist
 - 10) A clinical social worker (C.S.W. or L.C.S.W.)
 - 11) A marriage, family and child counselor (M.F.C.C.)

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

18. A **Year** is a twelve month period starting each January 1 at 12:01 a.m. Pacific Standard Time.
19. **Custodial Care** is care provided primarily to meet the personal needs of the patient. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

- 20. **Special Care Units** are special areas of a hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.
- 21. **Experimental Procedures** are all procedures not generally provided as treatment by the organized medical community in California, and those that are mainly limited to laboratory and/or animal research.
- 19. **Investigative Procedures** are experimental procedures that have progressed to a limited use on humans, but which are not widely accepted as proven and effective procedures within the organized medical community in California.
- 20. **Mental, Nervous Disorders** are any mental disease or disorder, whether the cause is organic, physical, mental or environmental or any combination thereof, or whether the symptoms are physical, mental or a combination thereof.

Any condition meeting this definition is included in it regardless of whether it produces only emotional symptoms or only physical symptoms such as headaches, sweats, trembling, nausea, or hysterical paralysis, or a combination of both. Plan limitations or exclusions of treatment of mental disease or disorder apply to the treatment of all conditions meeting this definition.

Examples of mental diseases or disorders include (but are not limited to) those which fall within the diagnosis Code 290 through 290.9 or 293 through 301.9 or 306 through 316 as listed in the "International Classification of Diseases," 9th Revision, Clinical Modification, Volumes 1 and 2, such as: schizophrenia, manic depression, and other conditions usually classified in the medical community as psychosis, depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; autism; hypochondria; personality disorders (including paranoid, schizoid, dependent, antisocial and borderline); dementia and delirious states; post traumatic stress disorder; cumulative trauma syndrome; organic brain syndrome; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa and bulimia.

- 21. **Severe Mental and Nervous Disorders** include the following psychiatric diagnoses specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia and bulimia. Severe mental disorders also include serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) or Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the *child's* age according to expected developmental norms, The child must meet one or more of the following criteria:
 - a. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self care, school functioning, family

relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

- b. The child is psychotic, suicidal, or potentially violent.
 - c. The child meets special education eligibility requirements under California law (Government Code Section 7570).
22. **Substance Abuse Treatment** is treatment of problems with alcohol and drug abuse and limited to service rendered through the Substance Abuse Treatment Plan. Please refer to Section IV. Substance Abuse Treatment- Beat It.
23. **Accidental Injury** is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.
24. **A Totally Disabled Member** is one who, because of illness or injury, is unable to work for income in any job for which he or she is qualified or for which he or she becomes qualified by training or experience, and who is in fact unemployed. A totally disabled family member is one who is unable to perform all activities usual for a person of that age.
25. **Administrator** is United Administrative Services.
26. **Plan** is the San Mateo County Electrical Workers Health Care Plan Active PPO Medical Plan.
27. **Coinsurance Amount** is the percentage amount payable by this plan, constituting benefits for covered expenses.
28. **Hospice** means an agency licensed or certified by the state in which it is located to provide hospice care.
29. **Hospice Care** means medically necessary and/or palliative treatment administered to a terminally ill person. Such treatment may include short-term care as an inpatient in a hospice unit or care in the person's home. All services must be planned, implemented and evaluated by an interdisciplinary team of trained volunteers and professionals, including at least a physician, registered nurse, clergy/counselors and other staff who have expertise in providing hospice care.
30. **Well Baby Care** is routine examinations and immunizations for eligible dependent children from birth to age three.
31. **Medical Emergency** is defined as medical services that are immediately required to treat a sudden, serious or unexpected illness or injury, or to provide medical services to alleviate severe pain associated with a sudden, serious or unexpected illness or injury.

Examples of medical emergencies are; uncontrollable bleeding; loss of consciousness or confusion, especially after a head injury; severe shortness of breath or difficulty breathing; apparent heart attack symptoms; and broken bones.

H. COVERED EXPENSES

1. Charges of a hospital for services and supplies rendered during confinement except that charges for room and board shall not exceed the hospital's semi-private room rate; charges of a hospital for confinement in an intensive care unit, contagion ward, isolation or private accommodation, when such confinement is certified by the attending physician as being medically necessary by reason of the severity of the insured person's condition.
2. Other Inpatient Hospital Care, subject to any limitations specified in the Schedule of Benefits, benefits include the use of operating rooms, delivery rooms, nurseries, recovery rooms, equipment therein and also the following:
 - A. Oxygen and carbon dioxide, including equipment and administration thereof.
 - B. Intravenous injection and solutions, such as glucose and serum.
 - C. Prescription drugs and biologicals.
 - D. Whole blood and blood derivatives, and administration and processing of same by the hospital, but not including blood procurement charges or charges for maintenance of a blood bank.
 - E. Dressings, splints, and casts, but not including special braces.
 - F. Diagnostic services; the following procedures to diagnose a condition, in response to specific symptoms, ordered or performed by a physician or other Licensed Health Care Professional licensed to render the services:
 1. Radiology, ultrasound and nuclear medicine services.
 2. Laboratory and pathology services.
 3. Electrocardiogram, electroencephalogram, ultrasound and other diagnostic procedures.
 - G. Anesthesia, including continuous epidural anesthesia when used for control of chronic, intractable pain due to terminal cancer or when used for control of acute post-operative pain following select procedures. Anesthesia services are not available in connection with care which is not a Benefit.
3. Outpatient hospital: surgical procedure, accidental injuries and medical emergencies (shock, acute poisoning, hemorrhaging, etc.) Emergency room treatment that is not considered a medical emergency will require a \$50.00 co-payment that is in addition to the annual plan deductible. The deductible will be waived if the treatment is considered a medical emergency.

4. Ambulatory Surgical Center
5. Radiation therapy, chemotherapy and hemodialysis treatment.
6. Skilled Nursing Facility or Rehabilitation Facility Treatment
 - A. For confinement in a skilled nursing or rehabilitation facility which immediately follows at least three days of hospital confinement. Includes ambulance service for transfer from hospital. Charges of a hospital for services and supplies rendered during confinement except that charges for room and board shall not exceed the hospital's semi-private room rate.
 - B. The services must be consistent with the illness, injury, degree of disability and medical needs of the patient. Benefits are only provided for the number of days required to treat the member's illness or injury. Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
 - C. The patient must remain under the active medical supervision of a Physician. The Physician must be treating the illness or injury for which the patient is confined in the Skilled Nursing Facility.
7. Surgeon's Charges by a Physician for the performance of surgical procedures.
8. Anesthesia Charges and its administration when these are not covered as Hospital charges.
9. Physician's Charges for medical care and treatment including;
 - A. Emergency room visits at hospital or clinics.
 - B. Inpatient hospital visits during a covered inpatient stay (except those relating to surgery), limited to one a day unless additional visits are needed due to the member's medical condition.
 - C. Extra time spent when the physician is detained to treat a member in critical condition that requires constant care.
 - D. Services of a physician at his office or in your home for treatment of illness or disease.
10. Nursing, Physiotherapy, and Occupational Therapy Charges for:
 - A. Private duty nursing care by a Nurse;
 - B. Treatment by a licensed physiotherapist; and
 - C. Treatment by a licensed occupational therapist.

The person providing the care must not live with or be related to the Insured Person or to his or her spouse.

11. Radiological and Laboratory Charges for diagnostic purposes and preventive screening tests that the physician determines to be medically necessary based on family medical history:
 - A. X-rays
 - B. Radiological treatment;
 - C. Diagnostic laboratory tests;
 - D. Low-dose mammography screening
 - E. Annual cervical cancer screening test (pap smear); and
 - F. Endoscopy and arthroscopy

12. Cosmetic Surgery and related charges is covered only:
 - A. As a result of an injury sustained while insured under this plan;
 - B. For replacement of diseased tissue surgically removed;
 - C. For the initial reconstruction of a breast after a mastectomy; and
 - D. Repair of bodily damage covered by disease and/or radiation treatment.

13. Women's Health and Cancer Rights Act of 1998

The plan covers medical and surgical benefits for mastectomies. This coverage includes:

- A. reconstruction of the breast on which the mastectomy was performed;
- B. surgery and reconstruction of the other breast to produce symmetrical appearance;
- C. prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

- The coverage is subject to the Plan's annual deductibles and coinsurance provisions.
14. Ambulance and Air Ambulance are allowed at the prevailing usual, customary and reasonable charges and subject to the following:

- A. Professional ambulance service when used to transport the insured person directly from the place where he/she is injured or becomes ill to the hospital(s) where treatment is given.
 - B. Professional ambulance service when also used to transport insured member from general hospital or emergency room to hospitals of specialty treatment, or to home hospital area.
 - C. Transportation by air ambulance from one hospital to another will be allowed when certified by the attending physician as being medically necessary by reason of the severity of the insured person's condition. This also includes transportation to the United States from a foreign country.
 - D. Services must be provided by an air ambulance, a licensed ambulance company, by professional non-air ambulance or on a regularly scheduled flight on a commercial airline when:
 - 1. Special and unique Covered Hospital Services are required which are not provided by a local Hospital;
 - 2. Transportation is medically necessary as deemed by the Administrator; and
 - 3. Transportation is to the nearest Hospital equipped to furnish the services.
 - E. Base charge, mileage and non-reusable supplies of a licensed ambulance or ambulance company.
 - F. Monitoring, electrocardiograms (EKG'S or ECG'S), cardiac defibrillation, cardio-pulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.
- 15. Home Health Care by approved home health care agency as recommended by physicians does not include custodial care.
 - 16. Physical therapy.
 - 17. Allergy testing, treatments and allergy injections.
 - 18. Dental benefit: inpatient hospital benefits are provided for up to three days during each period of hospital confinement for:
 - A. Dental surgery or extraction when required under general anesthesia;
 - B. Treatment to the teeth, gums or their dependent tissues when certified by the attending physician as being medically necessary, because the conditions under treatment are of such nature as to endanger the life of the insured person; and

- C. Dental care in accident cases - payment will be made for services incident to the treatment of injuries to the natural teeth, jaws and their dependent tissues customarily performed by dentists and oral surgeons. The services do not include the cost of or services for restoration of function or appearance (dentures, braces, etc.). These are covered by Delta Dental under the Dental plans.

19. Pregnancy and Maternity Care

Covered expenses for pregnancy and maternity care, including termination of pregnancy for medical reasons are eligible. Elective termination of pregnancy is not covered.

Covered expense for hospital benefits for routine nursery care of a newborn Child, if the Child's natural mother is enrolled under this Agreement and eligible for pregnancy and maternity coverage.

20. Organ and Tissue Transplants

Expenses for an organ transplant with such procedures limited to those transplants that are medically necessary and to the extent that they are not deemed experimental or investigative.

Experimental procedures are all procedures not generally provided as treatment by the organized medical community in California, and those that are mainly limited to laboratory and/or animal research.

Investigative procedures are experimental procedures that have progressed to limited use on humans, but which are not widely accepted as proven and effective procedures within the organized medical community in California.

21. Hospice care benefits: provided for a terminally ill person with a six-month or less life expectancy upon certification of a physician. The following services are covered:

- A. Nursing services by or under supervision of a registered nurse;
- B. Necessary medical equipment including oxygen;
- C. Home health aide; and
- D. Counseling.

22. Artificial limbs or eyes. This includes services of an orthotist and prosthetist in connection with evaluation or the fitting of an orthotic or prosthetic device when those services are billed as part of the charge of the artificial limbs or eyes.

Provided that benefits shall cover artificial limbs or eyes, only when such devices are:

- A. Affixed to the body externally;

- B. Required to replace all or any part of any limb or eye;
- C. Required to support or correct a defect or form or function of a permanently inoperative or malfunctioning limb or eye.

And further provided benefits do not extend to the repair or replacement of prosthetic devices occasioned by misuse or loss.

- 23. Rental or purchase of dialysis equipment, dialysis supplies and rental or purchase of other medical equipment and supplies, which are:
 - A. Ordered by a physician;
 - B. Of no further use when medical need ends;
 - C. Usable only by the patient;
 - D. Not primarily for the Member's comfort or hygiene;
 - E. Not for environmental control;
 - F. Not for exercise;
 - G. Manufactured specifically for medical use;
 - H. Approved as effective, and considered the usual and customary treatment of a condition as determined by the Plan; and
 - I. Not for prevention purposes.

Rental charges that exceed the reasonable purchase price of the equipment are not covered, as determined by the Administrator.

- 24. Prescription Drugs: Please refer to Section III, Prescription Coverage.
- 25. Chiropractic Care except for vitamin supplements, lumbar supports or pillows or massage therapy or maintenance therapy. Please see limitations on the schedule of benefits.
- 26. Routine physical exams are included as a benefit only up to \$200 per calendar year. Services eligible under the Physical Exam Benefit are the physician's charge for performing the physical, routine laboratory test, routine x-ray procedures and immunizations.
- 27. Charges for oxygen and the rental of equipment for the giving of oxygen.
- 28. The plan will reimburse Covered Expenses, for Routine Patient Care Costs in connection with participation in Cancer Clinical Trials as defined below.

A. Cancer Clinical Trials - Definition

Phase 1, Phase II, Phase III and phase IV cancer clinical trials, if all the following conditions are met:

The treatment provided in a clinical trial must either:

1. Involve a drug that is exempt under federal regulations from a new drug application, or
2. Be approved by:
 - a) One of the National Institutes of Health;
 - b) The Federal Food and Drug Administration in the form of an investigational new drug application;
 - c) The United States Department of Defense

B. Routine Patient Care Costs – Definition

The costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the Plan, including health care services which are:

1. Typically provided if a clinical trial were not involved.
2. Required solely for the provision of the investigational drug, item, and device of service.
3. Clinically appropriate monitoring the investigational item of service.
4. Used to prevent complications arising from the provision of the investigational drug, item, device or service.
5. Are considered to be reasonable and necessary care arising from the provision of the investigational drug, item, device or service, including the diagnosis or treatment of the complications.

C. Routine Patient Care Costs do not include any of the following:

1. Drugs or devices not approved by the federal Food and Drug Administration that are associated with the Cancer Clinical Trial.
2. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.

3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the Plan.
5. Health care services customarily provided by the research sponsors free of charge to patients enrolled in the trial.

Additional Provisions

1. The covered Person must be diagnosed with cancer for Routine Patient Care Costs to be eligible for this benefit.
2. Participation in Cancer Clinical trials must be recommended by the physician of the Covered Person after determining the Covered Person's participation has a meaningful potential to benefit the Covered Person.
3. The Cancer Clinical Trial must have a therapeutic intent.
4. Cancer Clinical Trials just to test toxicity are not eligible.

I. EXCLUSIONS AND LIMITATIONS

Benefits are **NOT** provided or **LIMITED** for the following:

1. Services or supplies that are not Medically Necessary as defined in Definitions and Experimental or Investigative procedures as defined in Definitions.
2. Services received before the Member's Effective Date or during an inpatient stay that began before the Member's Effective Date. Services received after the Member's coverage ends except as specifically stated under Extension of Benefits.
3. Any amounts in excess of the Usual, Customary and Reasonable allowance for professional services of non- Prudent Buyer Network providers.
4. Services not specifically listed as covered services.
5. Services for which the Member is not legally obligated to pay and Services for which no charge is made to the Member. Services for which no charge is made to the Member in the absence of insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines:
 - A. It must be internationally known as being devoted mainly to medical research;

- B. At least ten percent of its yearly annual expenditure must be spent on research not directly related to patient care;
 - C. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
 - D. It must accept patients who are unable to pay; and
 - E. Two-thirds of its patients must have conditions directly related to the Hospital's research.
6. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Member does not claim those benefits.
 7. Conditions caused by an act of war.
 8. Any service provided by a local, state or federal government agency, including a Veteran's Administration Hospital.
 9. Any services to the extent that the Member is entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid. Any services for which payment may be obtained from any other local, state or federal government agency (except Medi-Cal).
 10. Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.
 11. Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain. Custodial care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a Skilled Nursing Facility, except as specifically stated in Skilled Nursing Facility under Covered Expenses.
 12. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
 13. Treatment for hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or autistic disease of childhood.
 14. Braces, other orthodontic appliances or orthodontic services.
 15. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, except as specifically stated under Covered Expenses. Cosmetic dental surgery or other services for beautification.
 16. Routine hearing tests, except as provided in the Hearing Benefit in the next section.

17. Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated under Covered Expenses.
18. Outpatient occupational therapy, except following surgery, injury, or non-congenital organic disease.
19. Outpatient speech therapy, except following surgery, injury or non-congenital organic disease.
20. Charges in connection with Cosmetic Surgery are covered only if
 - A. Within 12 months after and as the result of an injury sustained while insured under this plan;
 - B. For replacement of diseased tissue surgically removed while insured under the plan;
 - C. For the initial reconstruction of a breast after a mastectomy for which benefits are paid under this plan; and
 - D. Repair of bodily damage covered by disease and/or radiation treatment while insured under this plan.
21. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to surgical treatment of obesity if:
 - A. Surgical treatment of obesity is necessary to treat another life-threatening condition involving obesity; and
 - B. It has been documented that non-surgical treatments of obesity have failed.
22. Procedures or treatments to change characteristics of the body to those of the opposite sex.
23. Sterilization reversal, treatment of infertility, artificial insemination and in vitro fertilization, including implantation of fertilized egg embryo or gamete transfer procedures and related care.
24. Orthopedic shoes (except when joined to braces) or shoe inserts, air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification. Educational services, nutritional counseling or food supplements and Telephone consultations.
25. Immunizations unless eligible under the Physical Exam Benefit or the Well Baby Benefit.
26. Any eye surgery solely for the purpose of correcting refractive defects of the eye such as near sightedness (myopia) and astigmatism.

27. Mental and Nervous as defined in Section II, G. Definitions is limited as noted in the Schedule of Benefits, Definitions and Covered Charges
28. Acupuncture treatment is limited as listed in the schedule of benefits,
29. There is a 12 month filing limit on the submission or claims. Charges for otherwise covered claims submitted more than twelve (12) months after the services or supplies were rendered that are the basis of the claim,
30. Services rendered outside the United States to an eligible individual during an absence from the United States for a period of more than sixty (60) days.
31. Charges which result from an injury which arose in the commission of a crime or participation in a riot or insurrection. Whether or not injuries arose on the commission of a crime will be determined by the Board of Trustees in its sole discretion, and may include circumstances in which no criminal charges have been brought.
32. Charges for pregnancy and related conditions for dependent children.
33. Any charges associated with the following procedures or services:
 - Radial Keratotomy
 - Lasik Surgery
 - Elective Abortions
 - Biofeedback and Hypnotherapy
 - Myofunctional therapy (facial exercises)
 - Behavioral training used for hyperactive children, weight counseling, and similar programs aimed at change behavior
 - Holistic medicine, therapeutic injections, chelation treatments

Note: There is no exclusion for pre-existing conditions under this plan.

J. COORDINATION OF BENEFITS

This Plan contains a Coordination of Benefits ("COB") provision which applies when an individual has medical or dental care coverage under more than one plan so that the total benefits available will not exceed, but can approach or equal, 100% of the allowable expenses.

Coordination of Benefits applies when a member or a member's children are also covered under a spouse's medical plan.

An allowable expense is any necessary, usual and customary expense covered at least in part, by one of the plans.

1. "Plan" means benefits or services provided by:

- A. Group insurance or group-type coverage, whether insured or uninsured;
- B. Employee-sponsored Blue Cross, Blue Shield or other pre-payment coverage;
- C. Group-type contracts;
- D. Coverage under a governmental plan;
- E. Coverage required or provided by law; and
- F. Medical benefits coverage in group or group-type and individual automobile "no fault" type contracts.

2. "Plan" does not include:

- A. A state plan under Medicaid;
- B. Benefits under a law or plan when, by law, its benefits are in excess to those of any private insurance plan;
- C. Individual or family coverage, except as provided above; and
- D. School accident type coverage. These cover grammar, high school, and college student for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis.

All benefits described in this booklet for medical coverage are subject to this provision.

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits available will not exceed the allowable expenses. No plan pays more than it would without the coordination provision.

3. A Plan Without A COB Provision

A plan without a coordination provision is always the primary plan. If all plans have such a provision the following rules apply:

- A. The plan covering the **patient directly, rather than as employee's dependent, is primary and others are secondary.**
- B. When this Plan and another plan cover the same child as a dependent of different persons, called "parents":
 - 1. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of a plan of the parent whose birthday falls later in that year; but

2. If both parents have the same birthday, the benefits of the plan which covered the other parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
- C. In the case of a child of separated or divorced parents, the benefits of the plan covering the child as a dependent will be determined as follows:
1. The plan of the natural parent having legal custody of the child;
 2. The plan of the current spouse, if any, of the natural parent, having legal custody of the child; and
 3. The plan of the natural parent not having legal custody of the child.
- D. The plan covering a person as an active employee is primary to the plan covering the person as a retired or laid-off employee or any dependent thereof.
- E. If 1, 2, 3 or 4 do not apply, the plan covering the patient longest is primary.

4. Coordination With Prepaid Plans

Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits provisions, in the event an Eligible Individual (i) has coverage under the indemnity program of this Plan, and (ii) has coverage under a prepaid program under another Group Plan (regardless of whether the Eligible Individual must pay a portion of the premium for such plan), and (iii) incurs expenses normally covered under the prepaid program, then this Plan will only reimburse the co-payments required of the Eligible Individual under the prepaid plan, and only if such co-payments are required of every person covered by that program. Except for the co-payments specified above, the Plan will not pay expenses of eligible employees or dependents covered by prepaid programs of other plans.

For purposes of this Plan, the term "prepaid program" shall include health maintenance organizations, individual practice associations, and other programs that the Board of Trustees in its sole discretion deems to be essentially similar to such prepaid arrangements.

5. Medicare Coordination of Benefits

This plan is the primary payer for active duty employees covered by Medicare. Since Medicare Benefits will, in large measure, duplicate the benefits provided under the plan described in this booklet, medical coverage under this plan for any insured individual, whether employee or dependent, will be modified to take Medicare benefits into account on the earliest date that any coverage under Medicare would become effective for that individual (generally, coverage under Medicare can become effective on the first day of the month in which the individual attains age 65). The Medical expenses benefits of this plan will be coordinated to maintain the existing level of benefits as described herein and will pay for covered expenses not payable by Medicare. This includes the deduction for hospital Medicare.

K. HOSPITAL AND PHYSICIAN PREFERRED PROVIDER PLAN

As mentioned, the Plan includes a Hospital and Physician Preferred Provider feature (PPO). A list of participating hospitals and doctors will be provided to you upon request. You may call United Administrative Services if you have any questions regarding status of specific hospitals and doctors at (408) 288-4400, or you may check the provider web site at www.bluecrossca.com.

L. THIRD PARTY LIABILITY AND ACCIDENTS

If any other person, firm or corporation shall be responsible for the sickness or injury of a covered employee or covered dependent:

1. The plan shall be entitled to full extent of its payment for benefits for such sickness or injury, to the proceeds of any settlement of judgment that may result from the exercise of any rights or recovery of the covered employee or dependent against such person, firm or corporation.
2. The covered employee or dependent shall hold such rights of recovery in trust for the Plan, but only to the extent of its payment for such benefits.
3. The covered employee or dependent shall execute and deliver to the Plan such instruments and papers submitted by the Plan as may be appropriate to secure the rights and obligations of the Plan and the employee or dependent established by this provision. The execution of an agreement to hold recovery proceeds in trust for the Plan shall be a condition precedent to the furnishing of benefits for such sickness or injury by the Plan.
4. The Plan shall pay out of such proceeds actually recovered a proportional share (based on the amount of recovery) of the fee incurred by the covered employee or covered dependent for attorney services in collecting from such person, firm or corporation, or its insurer.

Covered charges hereunder resulting from accidental injury involving a private passenger vehicle shall be reduced to the extent such charges are payable without regard to liability under any automobile insurance company.

M. RIGHT OF RECOVERY

Whenever payments for covered benefits have been made by this plan and those payments are more than the maximum payment necessary to satisfy the intent of this provision, regardless of who was paid, this plan has the right to recover the excess amount from any persons to or for whom those payments were made, or from any insurance company, service plan or any other organization or persons.

N. EXTENSION OF BENEFITS

1. If a member is Totally Disabled when coverage ends and is under the treatment of a Physician, benefits may continue to be provided for services treating the totally disabling illness or injury. No benefits are provided for services treating any other illness, injury or condition.
2. A member confined as an inpatient in a hospital or skilled nursing facility is considered Totally Disabled as long as the inpatient stay is medically necessary and no written certification of the total disability is required.
3. A member not confined as an inpatient who wishes to apply for total disability benefits must submit written certification by the physician of the total disability. The Administrator must receive this certification within 90 days of the date coverage ends under this agreement. At least once every 90 days while benefits are extended, the administrator must receive proof that the member's total disability is continuing.
4. Benefits are provided until one of the following occurs:
 - A. The member is no longer Totally Disabled; or
 - B. The maximum lifetime benefits are paid; or
 - C. The member becomes covered under another group health plan that provides coverage without limitation for the disabling illness or injury; or
 - D. The date 12 months following the date in which the disabled member's coverage ended.

O. 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.

P. 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.

III. PRESCRIPTION DRUG BENEFITS

A SELF-FUNDED PLAN

A. Prescription Drug coverage is offered through US-Rx Care.

	SCHEDULE OF BENEFITS	
	BENEFITS FOR COVERED SERVICES	BENEFITS FOR COVERED SERVICES
Prescription Drugs	Prescription Drugs are provided by US Rx-Care	Prescription Drugs are provided by US Rx-Care
Retail Purchase Generic or Brand	\$5 Generic/\$15 Preferred Brand/\$25 Non-Preferred Brand	\$5 Generic/\$15 Preferred Brand/\$25 Non-Preferred Brand
	BENEFITS FOR COVERED SERVICES	BENEFITS FOR COVERED SERVICES
Mail Order Purchase	\$10 Generic and \$30 Preferred Brand/\$50 No Preferred Brand 90 day supply	\$10 Generic and \$30 Preferred Brand/\$50 No Preferred Brand 90 day supply

Under the US-Rx Care three tier drug plan, nearly all covered prescription drugs are placed into one of these categories: Generic, Preferred Brand Name Drugs, and Non-Preferred Brand Name Drugs.

B. Generic vs. Brand

Generic drugs are copies of brand-name drugs that have the same intended use, side effects, dosage, risks, and safety. Generic drugs are often substantially cheaper than the brand name version, but have not been compromised in quality and effectiveness. The FDA requires that generic drugs be as safe and effective as brand-name drugs.

C. If they are the same in quality and effectiveness, why are Generic drugs cheaper than Brand drugs?

Generic drugs are only cheaper because manufacturers have not had the expenses of developing and marketing a new drug. When a new drug enters the market, a patent is granted that gives the company that initially developed the drug an exclusive right to sell the drug for a particular length of time. Once the patent expires, then generics can enter the market after FDA approval.

D. What is the Difference?

1. A generic drug has been FDA approved and has the same quality and effectiveness as a brand drug, but usually costs less.
2. A Preferred brand name drug, or formulary drug has been FDA and clinically approved by US-Rx Care, but does not have a generic alternative.

3. A Non-Preferred brand name drug, or non-formulary drug has been FDA and clinically approved by US-Rx Care, but has a lower cost alternative that has also been clinically and FDA approved.

E. Retail Pharmacy

For urgent fulfillment needs, almost any retail pharmacy in your neighborhood should accept your prescription benefit card for payment. You only pay the plan copayment when you pick up your medicine. **For medications you take routinely, utilize the Mail Order Service for convenience and lower cost.**

To verify local pharmacy participation in the plan network, you can search on-line at www.us-rxcare.com or call member services at 1-800-248-1062.

F. Refills

If your doctor has ordered refills, let your pharmacist know when you are ready to reorder.

G. Internet Orders

If you previously ordered a medication on-line, simply access the refill list at www.us-rxcare.com to quickly refill your prescription and check on the status of your order any time of the day or night. Or you can call in a refill request to the mail order pharmacy at 1-800-438-2014. If you are paying by check, your refill will be shipped upon receipt of payment.

H. Refill Requests By Mail

Place your order by mailing in a Mail Order Service form along with your payment preference. If paying by check instead of credit/debit card, please include payment together with your order along with any new prescriptions from your doctor.

1. What can I expect with mail order?

US-Rx Care Mail Service provides a convenient and cost-effective way for you to order your brand and generic prescriptions and have them delivered to you by mail in a timely manner.

- a. You will receive a 90 day supply compared to the 30 day supply in retail.
- b. You can expect your medicine to arrive approximately 3-7 days after your order and valid prescriptions are received. Standard 1st class shipping is included.

2. How do I utilize the mail order service?

- a. For medications you take routinely, the mail order service is your most convenient and lowest cost fulfillment option.

- b. For fastest delivery, place your order on-line at www.us-rxcare.com and provide Visa, MasterCard, Discover, or debit card information to cover any co-payment.
- c. You can forward your prescriptions to the mail order service one of three ways by law:
 - 1. Mail original prescriptions (not a photocopy) directly to the mail order pharmacy:

4230 L Street
Omaha, NE 68107
 - 2. Your physician can fax your prescriptions directly from their office to the mail order pharmacy at 1-402-342-4425.
 - 3. Your physician can phone in your prescription to the mail order pharmacy by calling: 1-800-438-2014.
 - 4. Prescriptions faxed to the pharmacy by a member cannot be accepted legally for fulfillment. If you are forwarding prescriptions yourself, you must mail the original to the pharmacy.
- d. To order refills, simply place any refill order on-line at: www.us-rxcare.com or call the pharmacy directly at 1-800-438-2014.
- e. If you prefer to order by mail instead of on-line, or you wish to pay by check instead of credit / debit card to cover any co-payment, simply copy and complete the Mail Service Order form included at the end of this booklet).
- f. You can also print the Mail Service Order form on-line at www.us-rxcare.com.
- g. You can expect your medicine to arrive approximately 3-7 days after your order; valid prescriptions and co-payment are received.

I. COMMON QUESTIONS

1. **What do I do if I lost my prescription benefits card?**

Contact member benefit services by phone to receive a new card by mail.

2. **How do I use my prescription benefits card for a family member?**

Your prescription benefits card is active for you and any other eligible, enrolled family members for as long as your benefits/ eligibility is active. To obtain prescription benefits for an enrolled family member, the fulfilling pharmacy just

needs the member's name and your benefits information. The US-Rx Care pharmacy system takes care of the rest.

3. I received a call from a US-Rx Care staff member. Why would they call me?

You may be contacted by US-Rx Care if there is concern about drug interactions or other safety issues related to medications you are taking. In addition, our staff also looks for ways to help you save out-of-pocket costs. If we believe that a lower cost, but equally safe and effective medication may be an option for you, we will let you and/or your doctor know. This is a free service offered to all members.

4. Who can I call to ask questions about the medications or a family member is taking?

Your physician is the best source of information regarding medications taken, since they have your full medical history to reference and have direct responsibility for your care. Your pharmacist can also answer general questions concerning dosing, side effects, or how best to take a particular medicine.

J. Need additional information or assistance

Please contact US-Rx Care at:

1. www.us-rxcare.com You can fill/refill prescriptions, locate a pharmacy, access group benefits, and get up to date drug information.
2. 1-800-248-1062 Call member services toll free to answer benefits questions.
3. Email us at info@us-rxcare.com for general inquiries

Benefit Information and Member Services On-Line:

Go to www.us-rxcare.com anytime of the day or night to access:

My Group Benefits – Provides group and prescription benefit plan information

Pharmacy Locator – Find a pharmacy in your local area including maps.

Drug Data – Allows members to search for detailed drug information including drug images.

Fill/Refill My Prescription – Order prescriptions on-line for home delivery.

What's New – Information about your organization or any special news events or links for members.

K. Exclusions and Limitations

Benefits are NOT provided for the following:

1. Medication which is to be taken by or administered to an individual in whole or in part on either an in-patient or out-patient basis in a licensed hospital, cancer center, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution.
2. Home infusion therapies (unless specifically included)
3. Medication for which the cost is recoverable under any Worker's Compensation or Occupation Disease Law or Any state or governmental agency.
4. Medication furnished by any other drug or medical service for which no charge is made to the member.
5. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.

The following are EXCLUDED from Prescription Plan coverage:

- a. Fertility Agents
- b. Anti-Acne Agents (to age 35)
- c. Prenatal Vitamins
- d. Contraceptives (Oral, Patches, Rings)
- e. Anti-Anxiety Agents
- f. Smoking Deterrents
- g. Growth Hormones
- h. Vitamins (including Prenatal)
- i. Anti-Obesity
- j. Drugs or devices prescribed solely for the treatment of sexual dysfunction.

**IV. EMPLOYEE ASSISTANCE PROGRAM – BEAT IT
A SELF-FUNDED PLAN for Alcohol and Chemical Dependency Treatment,
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.

A. 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 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.

B. 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.

C. Services Available Include:

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

D. Is Pre-Authorization Required?

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

E. Approved Recovery Facilities and Benefit

If you or your eligible spouse uses a Beat It! approved recovery facility, the Trust will pay up to \$6,200 of eligible charges. The total available for both you and your spouse is \$6,200 (\$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.

If you do not use a Beat It approved recovery facility, there is no benefit available under the plan.

WARNING

You will be responsible for costs in excess of \$6,200. By way of example, some facilities charge more than \$6,200 for residential treatment. You would have to self-pay the difference.

F. 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.

G. Lifetime Maximum Benefit

For each eligible Participant, the Trust will pay up to \$6,200 of eligible charges. That full amount could be for residential care, or it could be a combination, with a maximum of \$2,000

for outpatient services. The Participants Spouse also can use this benefit, but the \$6,200 maximum is combined for the Spouse and Participant. All eligible claims will be paid through the Claims Administrator, United Administrative Services.

V. HEARING BENEFITS A SELF-FUNDED PLAN

A. Hearing Benefit Rules

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.**

1. Percentage Payable: 80% of Usual, Customary and Reasonable charges, known as UCR. The percentage is applied to the covered hearing benefit charges.
2. Hearing Benefit Maximum: \$500 per ear
3. Although this benefit is not subject to an annual deductible, you will be responsible for the 20% not covered under this benefit and all charges in excess of the Hearing Benefit Maximum of \$500.
4. Covered Hearing Charge: A “covered hearing charge” is a charge that meets all of the tests listed below:
 - A. 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.
 - B. 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.
5. 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.
6. 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.

7. Exclusions:

No Hearing Benefit will be paid for the following:

- a. A hearing aid device that exceeds the specifications of the prescription;
- b. Batteries or other ancillary equipment, except those purchased with the Service or supply that is not necessary or that does not meet professionally recognized standards; and
- c. Service or supply that is otherwise covered by the medical plan the participant is enrolled in.

VI. 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 first enrollment period for Medicare Part D is November 15, 2005 through May 15, 2006; each subsequent year it is November 15th through December 31st.

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.

VII. COBRA

Refer to the San Mateo Electrical Workers Local 617 Plan Document for all information regarding rights you may have under The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

VIII. 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.

IX. FEDERAL NOTICES

A. 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.

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

C. 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:

1. PERMITTED USES AND DISCLOSURES OF PHI

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

2. REQUIRED USES AND DISCLOSURES OF PHI

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

3. AGREED TO USES AND DISCLOSURES OF PHI BY YOU AFTER AN OPPORTUNITY TO AGREE OR DISAGREE TO THE 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.

4. ALLOWED USES AND DISCLOSURES OF PHI FOR WHICH AUTHORIZATION OR OPPORTUNITY TO OBJECT IS NOT REQUIRED

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

5. 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.

6. ACCESS BY PERSONAL REPRESENTATIVES TO PHI

This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal

representative with limited health care power of attorney regarding specific treatment, such as use of artificial life support, is your representative only with respect to PHI that relates to decisions concerning this treatment. The personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to take any action.

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

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

7. THIS PLAN'S DUTIES

In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The 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.

8. MISCELLANEOUS

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

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

This Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages 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.

9. 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.

10. COMPLAINTS

If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer at the following address:

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.

11. SECURITY STANDARDS UNDER HIPAA

The Board of Trustees will implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of electronic protected health information that the Fund creates, receives, maintains, or transmits on behalf of the Plan. The Trustees will ensure that the adequate separation required by the Privacy Rule is supported by reasonable and appropriate security measures. The Trustees will ensure that any 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.

X. GENERAL PROVISIONS

A. 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.

B. 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. This does not preclude the Plan, 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.

C. MISCELLANEOUS PROVISIONS

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 no 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.

XI. POTENTIAL LOSS OF BENEFITS

You and/or your eligible Dependent(s) could lose your benefits and/or have payments delayed in at least the following circumstances:

A. PLAN EXCLUSIONS/CO-PAYMENTS

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

B. NOT MEDICALLY NECESSARY OR EXCEED UCR

The Plan will not pay for claims and expenses that are not medically necessary, refer to Section II. Medical Benefits, E. Medically Necessary Standards, even if prescribed by a physician or other medical provider or claims which exceed Usual Customary and Reasonable, known as "UCR", refer to Section II. Medical Claims, G. Definitions.

C. SUBROGATION THIRD PARTY CLAIMS

The Plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible. See Section II, L. Third Party Liability and Accidents

D. COORDINATION OF BENEFITS

If Dependents are covered by more than one Plan, this Plan may not be responsible for many claims. Please refer to Section II, J, Coordination of Benefits.

E. FAILURE TO ENROLL IN MEDICARE PARTS A AND B

If you are eligible and fail to enroll in Medicare parts A and B, the Plan will not pay many of your claims. Please refer to the Plan Document for additional information.

F. WORK-RELATED INJURIES

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

G. RIGHT TO RECOVER CLAIMS PAID OR OFFSET OF FUTURE CLAIMS

The Plan has the right to recover any amounts improperly paid. The Plan may offset any amounts owed to the Plan against any claims that you and/or a Dependent incur in the future.

H. INADEQUATE OR IMPROPER EVIDENCE

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

I. PROHIBITED EMPLOYMENT IN THE ELECTRICAL INDUSTRY

If you engage in certain kinds of work in the Electrical Industry, known as Prohibited Employment, you will no longer be entitled to Retiree Health and Welfare benefits.

J. FAILURE TO FILE COMPLETE APPLICATION

Benefits may not be payable until a completed application and other forms required by the Trust Fund Office are received by the Trust Fund Office.

K. INCOMPLETE INFORMATION/FALSE STATEMENTS

If you fail to provide requested information or give false information to verify disability, age, beneficiary information, marital status or other vital information, coverage under the Plan or benefits provided may be postponed or cancelled.

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

L. PLAN TERMINATION

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

XII. 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, and Medical.
- 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 40 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 31st, and the Trust's records are maintained on that basis.
8. **Employer Identification Number:** 94-6077920
9. **Plan Number:** 501
10. **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
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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
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11. **Name and Address of Contract Administrator:**

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

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

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

XIII. 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

The Trust has entered into contracts that can be used by Employees and Dependents enrolled in the Self-Funded Medical Plan. The Trust is responsible for paying claims submitted by providers.

United Administrative Services Inc.

1120 Bascom Avenue

San Jose, CA 95128

Phone: (408) 288-4855

Third Party Administrator

Administers the self-funded plans. Does not guarantee payment of benefits.

US-Rx Care

20 River Ct #2908

Jersey City, NJ 07310

866-770-6007

Pharmacy Benefits Administrator

Provides the self-funded prescription drug plan for participants and dependents. Does not guarantee payment of benefit

Westport Insurance Corporation**A Swiss RE Company**

5200 Metcalf

P.O. Box 2991

Overland Park, KS 66201-1391

913-676-5200

Specific Stop Loss Insurance Coverage

Claims arising from the self-funded medical for employees and dependents are paid directly from Trust assets, although a premium is paid to an insurance company for specific stop loss insurance coverage for self-funded medical benefits. Does not guarantee payment of benefit

Beat It Program, Inc.

P. O. Box 20896

San Jose, CA 95160

408-436-2392

Substance Abuse Plan

Administers Drug and Alcohol Plan for active and retired participants, Does not guarantee payment of these benefits.

Anthem Blue Cross Prudent Buyer Plan

21555 Oxnard Street

Woodland Hills, CA 91367

PPO Access, Utilization Review and Case Management services.

The preferred provider organization is responsible for the administration of contracts with physicians, specialists, hospitals and clinics. Anthem Blue Cross also administers case management and utilization review that reviews the setting, necessity and quality of health care provided to Employees and Dependents enrolled in the Self-Funded Medical Plan. Does not guarantee payment of these benefits.

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".

XIV. STATEMENT OF ERISA RIGHTS

A. YOUR RIGHTS UNDER ERISA

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

1. Examine, without charge, at the Plan Office and at other specified locations such as work sites and the Union Office, documents governing the Plan, including Collective Bargaining Agreements and the annual report (Form 5500 series) filed with the Department of Labor.
2. Obtain copies of Plan documents and other information (which is required by law to be furnished) upon written request to the Plan. Pursuant to ERISA, the Plan office may require that you pay a reasonable charge for the copies (not to exceed 25 cents a copy).
3. Receive a summary of the Plan's annual financial report, known as a Summary Annual Report ("SAR"). The Plan is required by law to furnish each Participant with this summary annual report.

B. PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

C. ENFORCING YOUR RIGHTS

If your claim for a Plan benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time limits.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of certain Plan documents (required to be furnished) or the latest annual report (Form 5500) from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the Court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator or the Administrator's delegate.

If you have a claim for benefits which is denied or ignored, in whole or in part, and which is upheld on appeal (or ignored), you may file suit in a state or federal court. As summarized earlier in this booklet, any lawsuit must be filed within two years of the denial on appeal or other action, omission or decision which adversely affected you or your benefits.

In addition, if it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are unsuccessful, the court may order the person you have sued to pay these court costs and fees. If you lose (for example, if it finds your claim is frivolous), the court may order you to pay these costs and fees. No lawsuit may be filed (started) more than two years after services were provided or benefits partially or totally denied or an otherwise adverse determination was made against you.

D. ASSISTANCE WITH YOUR QUESTIONS

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

**U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue NW
Washington, DC 20210**

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at (866) 444-3272 or contact the EBSA field office nearest you.

You may find answers to your questions and a list of EBSA offices at www.dol.gov/ebsa/welcome.html.