

**RETIRED  
SAN MATEO ELECTRICAL  
WORKERS HEALTH PLAN  
(IBEW LOCAL 617)**

**SUMMARY PLAN DESCRIPTION  
RETIREES AND EARLY RETIREES**

**March 9, 2009**

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### ALERT

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

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

January 1, 2009

Dear Participant:

This booklet known as a Summary Plan Description contains information regarding your Retired San Mateo Electrical Workers Health Care Plan and an explanation of the eligibility provisions for Early Retirees, ages 55-64 and Retirees, age 65 and over. The substance of your medical benefits are covered under the HMO and Self-Funded PPO Medical Plan. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Administrative Office at (866) 577-4239.

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

*For details on your benefit coverage, please refer to the Provider's Evidence of Coverage or the Self-Funded PPO Medical Plan Summary. These documents are the binding documents between the Insurance Plan or Self-Funded Plan and its participants. You should review the booklets and other documents furnished by the entities providing benefits for the Plan.*

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

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.

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

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 Services  
1120 S. Bascom Ave.  
San Jose, CA 95128  
408-288-4400

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.

### **LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS**

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

**You are not entitled to rely upon oral statements of Employees of the 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 an 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-payments 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 this 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**

### **A. Early Retiree Eligibility**

All participants (and their eligible dependents) who are or have been eligible under the San Mateo Electrical Workers Health Care Benefits Plan for 10 of the last 15 years and 2 of the last 5 years immediately preceding date of retirement, who have been approved for and are receiving pension benefits from the San Mateo County Electrical Construction Industry Retirement Trust (IBEW Local 617) who **are ages 55 – 64 and** have coverage under the San Mateo Electrical Workers Health Care Benefits Plan at their retirement date, shall be eligible for the Early Retiree Plan health and welfare benefits then in effect, if any.

### **B. Effective Date**

An eligible Early Retiree's effective date shall be the first day of the month following the date he or she meets the above requirements, and remits the premium contribution for their chosen coverage. The cost to the Early Retiree for health and welfare benefits will depend upon the amount of future Employer contributions made on their behalf and the Plan's earnings, expenses and asset appreciation or depreciation.

To be eligible for Benefits, an Early Retiree is required to make a contribution. The Board of Trustees will determine from time to time the contribution rate for all retirees.

### **C. Retiree Eligibility**

All participants (and their eligible dependents) who are or have been eligible under the San Mateo Electrical Workers Health Care Benefits Plan for 10 of the last 15 years and 2 of the last 5 years immediately preceding date of retirement, who have been approved for and are receiving pension benefits from the San Mateo County Electrical Construction Industry Retirement Trust (IBEW Local 617) who **are age 65 and older** have applied for and are receiving Medicare Parts A and B, **and** who have coverage under the San Mateo Electrical Workers Health Care Benefits Plan at their retirement date, shall be eligible for the Retiree Plan health and welfare benefits then in effect, if any.

### **D. Effective Date**

An eligible Retiree's effective date shall be the first day of the month following the date he or she meets the above requirements, and remits the premium contribution for their chosen coverage. The cost to the Retiree for health and welfare benefits will depend upon the amount of future Employer contributions made on their behalf and the Plan's earnings, expenses and asset appreciation or depreciation.

**To be eligible for Benefits, a Retiree is required to make a contribution. The Board of Trustees will determine from time to time the contribution rate for all retirees**

## E. Covered Dependents

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

The rules for a Dependent child shall be:

1. Blood Descendent: A blood descendent of the first degree;
2. 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;
3. Stepchild: A stepchild residing in the employee's household;
4. 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;
5. 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;
6. Age Limit for Children/Students: Covered Dependents are eligible for benefits provided from birth through the age of 18 years, provided such children are unmarried, and dependent upon their parents for support and maintenance, and reside with you in a parent-child relationship. Children also include those from age 19 years up to age 25 years provided they are attending an accredited and state licensed technical school or institution of higher education on a full-time basis, are unmarried and are dependent upon you for support and maintenance
7. Student Breaks (Summer Months and Periods of Vacation):
  - a. 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.
  - b. 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:
    - (1) 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

- (2) 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
- (3) The Dependent child must intend on again enrolling on a Full-Time basis the quarter/semester immediately preceding 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

8. **Disabled Children:** A dependent child also includes a child after his 19<sup>th</sup> 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 19<sup>th</sup> birthday, up to age 25.

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

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

## **F. Domestic Partners**

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 Participant's domestic partner will be covered provided the domestic partnership meets the following criteria:

1. Both persons must file a Declaration of the Domestic Partnership with the Secretary of the State of California and provide a copy to the Administrative Office;<sup>\*1</sup>
2. Both persons must have a common residence;
3. Neither person may be married to someone else or be a member of another domestic partnership with someone else that has not been terminated;
4. The two persons must not be related by blood in any way that would prevent them from being married to each other;

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

5. Both persons are at least 18 years old;
6. Both persons must be members of the same sex, or, if opposite sex, one or more persons must be over age 62; and
7. Both persons must be capable of consenting to the domestic partnership.

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

The election by a Participant to add a domestic partner may have certain Federal income tax implications. Under Federal tax law, the fair market value of health coverage provided to a domestic partner is a taxable benefit to the Participant. (Please note that domestic partner benefits are not taxable under California law.) Each year the Fund will calculate the fair market value of the domestic partner coverage and this information will be sent to participating employers. The Participant's employer is then responsible for including the imputed income on the Participant's wages and withholding any FICA, FUTA, Medicare and Federal income taxes as applicable.

**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.

**G. Automatic Coverage for a Newborn Child– If Plan Notified Within 31 days**

A newborn or newly adopted child of any age will automatically be covered for the first 31 days of medical benefits on the date the child becomes a Dependent. However, you are required to apply for Dependent coverage for that child within 31 days of the child's birth or of the adopted child's placement in your home in order to continue that child's coverage beyond the first 31 days. You are urged, however, to enroll the new child immediately. **If you fail to do so there is no coverage.**

If you are required to contribute toward the cost of insurance and if the child's coverage terminates because you fail to apply (or pay the required contribution) within the 31-day period, no benefits will be payable. The Individual Purchase Rights and the extended Benefits (after termination of coverage) will not apply to the child.

## H. Qualified Medical Child Support Order (QMCSO)

The Participant must timely provide the Trust Fund Office with a copy of any court order that establishes the Participant's legal obligation to maintain coverage on a Dependent Child including a QMCSO.

A QMCSO recognizes an eligible child's right to receive Plan benefits as a beneficiary of an eligible Plan Participant. The child, to be covered for benefits by this Plan, must meet Plan requirements for an eligible Dependent child including age requirements.

The steps that will be followed to establish and determine whether a court order would qualify as a QMCSO are:

1. The Participant must provide the Plan Office with a copy of the court order and/or QMCSO.
2. Within thirty (30) days after receipt of the QMCSO, the Plan Office or the Plan's legal counsel will notify the Participant in writing if the court order and/or QMCSO is acceptable to the Plan.
3. If the Plan determines that the court order and/or QMCSO is not acceptable, or if additional information is required, the Participant will be notified in writing by the Plan or the Plan's legal counsel.
  - a. **If a QMCSO is denied.** The notice will describe the reasons for denial. There is a right to appeal a denial. A summary of the Plan's appeal procedures will be included in the notice of denial. In most instances however, you will simply be asked to revise the order in such a way that it is a proper QMCSO.
  - b. **If additional information is required.** The notice will describe what is needed. There will be sixty (60) days to respond. If you do not respond within the sixty (60) days, the request for the QMCSO will be deemed canceled.

The Plan requires that the Participant and all of his eligible Dependents be enrolled under only one Health Plan option. Therefore, a Participant must select and enroll in a Health Plan option that would be available to the Participant, the child(ren) covered under the QMCSO and to the Participant's other eligible Dependents. If a Participant enrolls in a Plan that would not be available to the child(ren) covered under the QMCSO because they reside outside of the Plan's service area, the Participant will be required to enroll in another Health Plan option that would cover the child(ren). The Plan will follow the requirements of the QMCSO even if that requires that the Participant be forced to enroll in a different Plan option.

If a Participant has not enrolled in a Health Plan option and the Plan receives a QMCSO, the Plan will enroll the child(ren) for coverage, independent of the Participant, in the Kaiser Plan (assuming the child resides in a Kaiser area). If the child resides outside of a Kaiser service area, the Plan has the power and the discretion to enroll the child(ren) using its best judgment in the interpretation of a QMCSO. Please be aware that if a child covered under a QMCSO was enrolled independent of the Participant neither the Participant nor any other Dependents would be considered enrolled in the Plan until such time as the Participant has

completed all Enrollment Procedures. In addition, the Participant and any other eligible Dependents would then be limited to enrollment into only that Health Plan option that the child covered under the QMCSO has been enrolled in.

### **I. Termination of Dependent Eligibility**

A Dependent's eligibility terminates when the Participant's coverage terminates or when the individual ceases to meet the Plan qualifications of an eligible Dependent.

A Dependent child(ren) whose loss of coverage is due to the death of the Participant may continue coverage at rates established by the Board of Trustees for so long as the Dependent continues to meet the definition of an eligible Dependent child.

Continuation of coverage under the Surviving Spouse/Child(ren) Plan is part of the Retiree Health and Welfare Plan and benefits of the Retiree Plan would be applicable subject to timely receipt of the required monthly premiums.

### **J. Medicare Coordination--YOU ARE REQUIRED TO ENROLL**

Medicare is our country's federal health insurance program for people age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income (SSDI) benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin.

Under the Medicare program, the hospital insurance portion is called Medicare Part A; and the medical insurance portion, such as for the cost of physicians, is called Medicare Part B.

Medicare Part A is financed by payroll taxes, and, if you are eligible to receive it based on your own--or your spouse's--employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage.

The Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) and Part B (medical benefits). This means you must enroll in **both Medicare Part A and Part B**, as soon as you are eligible for Medicare. If you do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid and you will be required to pay an additional Retiree Health and Welfare Premium.

## IMPORTANT NOTICE:

### ENROLL IN MEDICARE

You must notify the Trust Fund Office immediately upon becoming eligible for Medicare. **To be eligible for Retiree Health and Welfare benefits under this Plan you and/or your eligible Dependent(s) are required to formally enroll in both Medicare Parts A and B and pay the required premium as soon as you and/or your eligible Dependent(s) are entitled to coverage. *Note: Because Medicare benefits are assigned to your medical plan, you and/or your eligible Dependents can only enroll in one HMO Medicare Plan.***

**If you elect not to enroll in Medicare (Part A and/or Part B), the Plan will charge you a monthly penalty premium in addition to the rate currently paid, until the Medicare coverage goes into effect.**

It is important that you enroll in Medicare Part B when you first become eligible. If you do not, Medicare generally imposes penalties which will significantly increase your Part B premium once you do enroll. For enrollment and eligibility information, you should call Social Security at (800) 772-1213. You can also find Medicare information on the Internet at [www.medicare.gov](http://www.medicare.gov).

To avoid loss of protection, you (or your Dependents) must enroll for Parts A and B of the Federal program during the **three months** before the month in which you (or your Dependents) will become eligible for Medicare. Social Security will automatically enroll you in Medicare Parts A and B. If you have not received your Medicare Card within 2 months of your Medicare eligibility, you should contact the Social Security Administration. Please remember that if you and/or your Dependent are under age 65 but eligible for Medicare, you and/or your Dependent must also enroll for Parts A and B.

## **II. RESERVE ACCOUNT (HOUR BANK)**

An eligible Participant's Hour Bank and respected monies will be transferred from the San Mateo Electrical Workers Health Care Benefits Plan to the Retired San Mateo Electrical Workers Health Care Benefits Plan on the effective date of his/her retirement.

The dollar amount to be transferred will be the equivalent of the current cost of monthly benefits, multiplied by the number of full months (hour bank balance divided by 120) in the Participant's hour bank.

**The Board of Trustees reserves the right to reduce and/or terminate your reserve hours (hour bank) at any time, including hours previously earned but not used. There is no vested right to such hours.**

## ALERT

### **BENEFITS MAY BE CHANGED OR ELIMINATED IN THE FUTURE.**

**NOTE:** In all cases, initial eligibility and continuing eligibility under the Retiree Plan depends on the Board of Trustees continuing the Retiree Plan. The Board of Trustees reserves the right to charge for, modify or terminate the Retiree Plan at any time. The Retiree Plan is not a vested right. Eligibility rules, premium amounts, and benefit levels and types may change at any time in the future. The charges for such coverage will likely increase in the future.

Disability Income, Hearing, Life and AD&D coverages cease as of the date retiree health benefits begin.

### **III. TERMINATION OF COVERAGE**

#### **A. Retiree**

If a Retiree returns to active employment within the Electrical Industry, the Retiree and his or her dependents lose their coverage under this Plan immediately and will lose the hours in his/her Hour Bank.

A Retiree who returns to work in the Electrical Industry for one or more hours for an employer that has not contributed to San Mateo Electrical Workers Health Care Benefits Plan shall lose his or her coverage under this Plan **at any time now or in the future. This includes his or her dependents.**

Eligibility for benefits under this Plan will also terminate effective the first of the month that the required Retiree contributions are not received in a timely manner in accordance with rules adopted by the Board of Trustees.

Dependent eligibility for benefits under this Plan terminates when the Retiree's coverage terminates, except for when the Retiree dies, as summarized below.

Dependent eligibility also terminates when the individual ceases to be an eligible dependent; for example, if the stepchild or other dependent no longer resides with or is no longer entirely supported by the Retiree, coverage will terminate.

#### **B. At Covered Retired Employee's Death – Limited Coverage**

Widow/Widower, age 65 or older, who reside outside the Retiree Plan's approved California Medicare Supplement or Medicare HMO Plan service area, shall receive a reimbursement on a per month basis. The contribution rate will be determined by the Board of Trustees and will be updated on an annual basis or at such other times as the Trustees determine. Reimbursements are made only to eligible Widow/Widowers.

The Health Benefits coverage for the Retired Employee's spouse and dependent children who were enrolled in the Plan as Dependents on the date of death will remain in force, provided any required contributions are made and received in a timely manner, until the earliest of:

1. The date the Plan terminates, or the date insurance would have ceased for any other reason had the death not occurred; or
2. The date the surviving spouse, if any, remarries.

### **C. Dependent**

Your Dependent coverage will terminate on the earlier of:

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

In addition, under certain conditions, your Dependent's Medical expense coverage may be continued after the date it would terminate. For further information, refer to the COBRA section beginning on page 15.

## **IV. MEDICAL BENEFITS**

The Trust Fund provides medical care through a HMO or a Self-Funded PPO Medical Plan arrangement. Separate booklets are available at the Administrative Office which describes these coverages.

***For details on your benefits coverage, please refer to the HMO Plan's Evidence of Coverage or the Self-Funded PPO Medical Plan's Evidence of Coverage. These documents are the binding documents between the Health Plan and its participants.***

## **V. DENTAL BENEFITS**

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

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

## **VI. VISION CARE BENEFITS**

The Trust Fund provides vision care benefits through a self-funded vision program. A separate booklet is available at the Administrative Office which describes this coverage.

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

## **VII. PRESCRIPTION DRUG BENEFITS**

The Trust Fund provides prescription drug benefits through a self-funded prescription drug program. A separate booklet is available at the Administrative Office with complete benefit coverage, limitations, and exclusions.

***For details on your benefit coverage, please refer to Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Prescription Drug Program and its participants.***

## **VIII. NOTICE TO THOSE ELIGIBLE FOR MEDICARE PART D**

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

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

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

## **IX. COBRA**

### **A. Eligibility for COBRA**

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

#### 1. Eligibility Definitions:

- a. Qualified Beneficiary: Any Retired Employee or dependent whose eligibility terminates because of a Qualifying Event.
- b. Qualifying Event for Dependents:
  - 1) The death of the Retired Employee;
  - 2) The divorce or legal separation of the Retired Employee from his or her spouse;
  - 3) A Retired Employee on continuation coverage becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare);
  - 4) The date on which an eligible Dependent loses his or her status as an eligible dependent; and
  - 5) A Title XI bankruptcy of the Retiree's former employer from which he/she retired (includes a substantial elimination of coverage within one year before or after commencement of bankruptcy proceedings).<sup>2</sup>

It is not the responsibility of the Qualified Beneficiary to notify the Plan of the Qualifying Events described in 2), 3), or 4) above. It is the responsibility of the Retired Employee's employer to notify the Plan of the Qualifying Events described in 1) above.

2. COBRA Continuation Coverage will begin on the date that the Retired Employee or Dependent would normally lose coverage because of one of the above Qualifying Events.
3. COBRA Continuation Coverage will cease thirty-six (36) months after the date of the loss of coverage if the Qualifying Event is due to:
  - a) Death of the Retired Employee;

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<sup>2</sup> Continuation Coverage as a result of a bankruptcy proceedings is limited to Retirees who retired on or before the date of the substantial elimination of coverage and any other Covered Individual who on the day before such elimination, is a Plan beneficiary such as the Spouse, Surviving Spouse, Domestic Partner, Surviving Domestic Partner or Dependent Child of the Retiree.

- b) Divorce or legal separation of the Retired Employee from his or her spouse; and
  - c) The Date on which an eligible Dependent loses his or her status as a Dependent.
4. COBRA Continuation Coverage under this Plan will cease on the date when the Retired Employee's Employer no longer provides coverage under this Plan to any Retired Employee.
  5. COBRA Continuation Coverage will cease on the date an applicable premium has not been received by the Plan for the period of thirty (30) days after its due date.
  6. COBRA Continuation coverage will cease on the date on which the Qualified Beneficiary first becomes entitled to Medicare; however, his or her Dependents who were on COBRA may continue Continuation Coverage, such Dependents may continue Continuation Coverage for up to a total of 36 months, subject to the general termination provisions applicable to such coverage.
  7. COBRA Continuation Coverage will cease on the date on which the Qualified Beneficiary becomes covered under any other group health plan provided that this rule will apply only if the group health plan does not limit or exclude any pre-existing condition the Qualified Beneficiary may have.
  8. A Qualified Beneficiary who wishes to continue health and prescription drug benefits through COBRA may contact the Administrative Office for the cost of continuing these benefits.
  9. Terms of Coverage – Subsequent to a Qualifying Event, each Qualified Beneficiary will be given the opportunity to elect to continue benefits of this Plan for the Continuation Period. This Continuation Period will run concurrently with any other period of continued coverage described elsewhere in the Plan. No evidence of insurability will be required. Reasonable procedures will be adopted to administer this section in compliance with legal requirements.

When a Qualified Beneficiary elects COBRA Continuation Coverage, he or she will be required to pay for coverage at 102% of the applicable cost for similarly situated Retired Employees, except Qualified Beneficiaries will be required to pay 150% of the applicable cost during the 19<sup>th</sup> through 36<sup>th</sup> months of their coverage.

The coverage for a Qualified Beneficiary who elects COBRA Continuation Coverage will be identical to that of similarly situated Retired Employees.

## **X. 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.

## **XI. FEDERAL NOTICES**

### **A. Certification of Coverage Health Insurance Portability and Accountability**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides that plans must limit the time for which coverage is not provided for pre-existing conditions. (This Plan has no such exclusion; however, some other plans do.) The law requires that this Plan provide written certification of creditable coverage to you when your coverage ceases (under employer coverage and/or COBRA coverage) or when requested by you if your coverage is still in effect or if requested by you within two years after your coverage ends. The certification will specify the period(s) of creditable coverage under this Fund (including COBRA, if applicable) disregarding periods of coverage before a 63-day break. The 63-day break will not include any days between the loss of coverage and any secondary opportunity date to elect COBRA under the Trade Act of 2002.

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

United Administrative Services  
1120 S. Bascom Ave.  
San Jose, CA 95128

You (or someone on your behalf) should provide your name and the name(s) of your dependent(s) and an address(es) to which the certificate(s) should be sent. The notice will then be processed and sent on the earliest date that the Fund, acting in a reasonable and prompt fashion, can provide it. If you request, in writing, that the Fund send the certificate to another health plan or issuer and the other plan or issuer agrees, the certificate can be processed by means other than in writing, such as by telephone.

#### *Special Enrollment Rights*

There are no special enrollment (or late enrollee) requirements under HIPAA because Retirees and/or dependents cannot decline coverage under this Trust and new dependents may be added at any time subject to proof of birth, marriage, etc.

### **B. Newborns' and Mother's 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.

### **C. Women's Health and Cancer Rights Act of 1998**

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

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

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

### **D. 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, 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 Person 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. Duties of the Board of Trustees With Respect to PHI**

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have 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:

United Administrative Services  
1120 S. Bascom Ave.  
San Jose, CA 95128  
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.

## **XII. GENERAL PROVISIONS**

### **A. Acts of Third Parties**

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

1. The Retiree or dependent will be required to pay to the Plan or any entity providing benefits immediately any proceeds received by way of judgment, settlement or

otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance) arising out of any claims for damages by the individual or his or her heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the third party may be responsible;

2. Any Retiree or dependent who accepts payments from the Plan agrees that by doing so he or she is making a present assignment of his or her rights against such third party to the extent the payments made by the Plan. These rules are automatic, but the Plan may require that any participant or dependent sign an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require; and
3. Any Retiree or dependent who refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. Any Retiree or dependent who receives benefit payments and later fails to reimburse the Plan as set forth above will be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the employee or dependent has failed to reimburse, including reasonable interest on such unpaid funds.

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

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

## **B. Coordination of Benefits**

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

You may not reject coverage under another Plan, HMO and/or insurance company and/or not enroll in such other Plan, HMO and/or insurance company and then expect this Plan to be primary with respect to payment of your benefits. The other Plan, HMO and/or insurance

company would be primary (or you would be responsible for such claims/payments if they refuse such given your failure to enroll or action of unenrolling).

### **C. 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.

### **D. Exclusion for Fraud**

No benefits are paid for fraudulent claims or services or supplies by a covered Retiree, 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 Retiree and any person on whose behalf a fraudulent claim was submitted or paid is liable to the Plan for repayment of benefits paid and the amount of any premium paid to an HMO, PPO, insurance company or any other entity. This does not preclude the Plan, HMO, PPO, insurance company or other entity from bringing a lawsuit against any person who commits fraud to recover improperly paid benefits, services or supplies, including reimbursement for any attorney's fees and costs incurred to recover such amounts.

By way of example, if an Retiree improperly signs up a person as a dependent who is not lawfully a dependent under the Plan, both the Retiree 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.

### **E. Claims and Appeal Procedure**

#### *Health Plan*

Copies of the applicable appeals procedures are available from the pertinent insurance companies or other providers. The Plan's HMO, PPO and other entities have their own appeal procedures set forth in their applicable documents.

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

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

5. Information on the steps to be taken if you wish to submit your claim for review.

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

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

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

### *Appeal*

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

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

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

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

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

### *When a Lawsuit may be Started*

No Employee, Dependent, Beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein. A Participant may not start a lawsuit to obtain benefits until after either: (1) the Participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed

since Participant filed a request for review and Participant has not received a final decision or notice that an extension will be necessary to reach a final decision.

**No lawsuit may be filed (started) more that two years after services were provided or benefits partially or totally denied or an otherwise adverse determination was made against you or, if the Claim is for short term disability benefits, more than 2 years after the onset of the disability.** The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a "Participant" or "Beneficiary" of the Plan with the meaning of those terms as defined in ERISA. Such claim shall be limited to benefits due to him under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive.

## **F. Miscellaneous Provisions**

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

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

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

No retiree, 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 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.

**XIII. 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. 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.

**B. 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.

**C. Subrogation Third Party**

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 page 22 for Third Party Liability.

**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 page 23 for the rules of 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 page 9 for additional information.

## **F. Right to Recover Claims Paid or Offset of Future**

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.

## **G. Plan Exclusions/Co-Payments**

The Plan and any HMO or 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.

## **H. 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.

## **I. Incomplete Information/False**

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 attorneys' 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.

## **J. Plan Termination**

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

## **XIV. GENERAL INFORMATION (As Required by ERISA)**

- 1. Name and Address of the Plan:** Retired Electrical Workers of San Mateo Health Care Benefits Plan, 1120 S. Bascom Ave. San Jose, CA 95128.
- 2. Type of Plan:** This is a Health Care Plan, providing the following Health Care Benefits Plan –Hospital, Surgical, Medical, Dental, and Vision coverages.
- 3. Type of Administration and Method of Fund Benefits:** This Plan is administered by the Joint Board of Trustees. The Plan is funded by employer contributions as provided for in the collective bargaining agreement. Claims not related to HMO and insured providers are processed by a contract administrator.
- 4. Sponsoring Organizations:** The Plan is maintained in accordance with collective bargaining agreements between N.E.C.A., San Mateo Chapter and Local 617 of the

International Brotherhood of Electrical Workers Union. By writing to the Union, participants and beneficiaries may determine whether a particular employer is a sponsor of the Plan, and if so, the employer's address.

- 5. **Contributions:** Contributions to provide Plan benefits are paid by the sponsoring employers in accordance with their bargaining agreements "on a cents-per-hour basis".
- 6. **Appeal Procedure:** The procedure for file appealing denials are set forth on page 25 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 June 30<sup>th</sup>, and the Trust's records are maintained on that basis.
- 8. **Employer Identification Number:** 94-6763243
- 9. **Plan Number:** 001

**10. Names and Addresses of the Board of Trustees:**

Employer Trustees:

Mr. Robert Gonzales  
NECA  
1900 El Camino Real  
Menlo Park, CA 94025

Mr. Rich Pellizari  
NECA  
1900 El Camino Real  
Menlo Park, CA 94025

Mr. Dennis Agresti  
NECA  
1900 El Camino Real  
Menlo Park, CA 94025

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. John Valdez  
IBEW Local 617  
1701 Leslie Street  
San Mateo, CA 94402

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

United Administrative Services  
1120 S. Bascom Ave.  
San Jose, CA 95128  
408-288-4400

**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  
Telephone: (415) 677-9440

**XV. HIPAA**

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

**List of Providers**

United Administrative Services  
1120 S. Bascom Ave.  
San Jose, CA 95128  
Administers the Self-Funded Plan; does not guarantee payment of benefits.

Anthem Blue Cross Prudent Buyer Plan  
21555 Oxnard Street  
Woodland hills, CA 91367  
Administers the PPO contracts, case management and utilization review for the Self-Funded Medical Plan; does not guarantee payment of benefits.

Delta Dental  
100 First Street  
San Francisco, CA 94105  
Provides prepaid dental benefits with guaranteed payment of these benefits.

Kaiser  
1800 Harrison Street, 13<sup>th</sup> Floor  
Oakland, CA 94120  
Provides prepaid medical benefits with guaranteed payment of these benefits.

Vision Service Plan  
333 Quality Drive  
Rancho Cordova, CA 95670  
Administers the self-funded vision plan for participants and dependents.

US-RxCare  
20 River Ct. #2908  
Jersey City, NJ 07310  
Provides self-funded prescription drug benefits; 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".

## **XVI. STATEMENT OF ERISA RIGHTS**

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

- Examine, without charge, at the Plan Administrator's office all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies of some of these documents.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report at no cost to the participant.
- Continued health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as the result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description on the rules governing your COBRA continuation coverage rights.

You should be provided a certificate of creditable coverage free of charge, from your group health Plan or health insurance issuer as follows:

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

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

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

operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interests of you and other Plan participants and beneficiaries.

No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the plan or exercising your rights under ERISA. If your claim for benefits is denied or ignored, in whole or in part, you must receive a written explanation for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA there are steps you can take to enforce the above rights.

For instance, if you request materials from the Plan and do not receive them within 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 \$110.00 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a State or Federal Court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court.

The Court will decide who should pay the court costs and legal fees. If you are successful, the Court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

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](http://www.dol.gov/ebsa/welcome.html).