NECA
NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION

Solano-Napa Counties Electrical Workers' Health and Welfare Plan

2009 Edition

SOLANO-NAPA COUNTIES ELECTRICAL WORKERS HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION
PLAN DOCUMENT

P.O. Box 1306
San Ramon, California 94583
925/208-9980

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SOLANO-NAPA COUNTIES ELECTRICAL WORKERS HEALTH AND WELFARE TRUST FUND

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Dear Plan Member, Spouse and Dependent:

This booklet summarizes the benefits offered by the Solano-Napa Counties Electrical Workers Health and Welfare Trust Fund. Eligible active and retired employees are offered medical benefits provided by Kaiser Foundation Health Plan. The Plan also provides dental care, life insurance, and accidental death and dismemberment benefits for active employees and their eligible dependents. Dental care, but no life insurance or accidental death and dismemberment benefits, is offered for retired employees and their eligible dependents. Except for life insurance and accidental death and dismemberment benefits, Plan benefits are payable only for non-occupational illnesses and injuries.

Only the full Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan, including questions about your eligibility for benefits and the amount of any benefits payable to you. The Board also has discretion to make any factual determinations concerning any claims under this Plan not delegated by contract to a health care provider or insurance carrier. 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 has authorized the Fund Office to respond in writing to your written questions. If you have a question about your benefits, you should write to the Fund Office for a definitive answer. To obtain an accurate answer you can rely on, you will need to provide complete and accurate information about your situation in writing to the Fund Office and receive a written reply.

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

Plan rules and benefits may change from time to time. If this occurs, you will receive a written notice explaining the change. Benefits, subsidies, hour banks and all other aspects of the Plan may be modified at the discretion of the Trustees. The benefits provided herein are not vested. However, any claim incurred prior to a Plan modification will not be affected by a subsequent modification of the Plan. Please be sure to read all Plan communications and keep them with your booklet.

THE BOARD OF TRUSTEES

Plan benefits for employees, retirees and their eligible dependents are not guaranteed.

The Trustees may in their sole discretion modify or terminate benefits under this Plan, or add or delete insurance carriers or benefit providers, at any time and for any class of participants, whether before or after commencement of coverage under the Plan.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan and contractual agreement between the Trust and its participating life and health insurance carriers as they exist at the time the claim occurs.

This Summary Plan Description is intended to be a summary of the eligibility rules and benefit provisions of the Health and Welfare Trust Fund. If this Summary Plan Description conflicts in any way with the Second Revised Eligibility Rules for the Solano-Napa Counties Electrical Workers Health and Welfare Trust Fund, the Rules and Regulations Providing Dental Benefits for Eligible Employees, and/or any contractual agreements between the Fund and its participating life and health insurance carriers, the Rules and Regulations and contractual agreements shall govern. The Trustees are the sole judges of the application and interpretation of the eligibility and benefits provisions applicable to the Fund and its participants.

It is your responsibility to notify the Fund Office, in writing, of any of the following events:

(1) The addition of any new dependents by legal marriage, birth or legal adoption must be supplied within thirty (30) days;

(2) If you divorce or legally separate from your spouse;

(3) If a dependent child ceases to be a dependent under the terms of this Plan;

(4) If you receive a determination by the Social Security Administration that you, your spouse or your eligible dependent is permanently and totally disabled, or that you are no longer considered to be permanently and totally disabled.

(5) If you change your address.

Employees, retirees and their eligible dependents must notify the Fund Office within thirty (30) days following any of the events described in paragraphs (1) through (4).

If you fail to notify the Fund Office within thirty (30) days following the addition of a new dependent, you will not be able to enroll the dependent in the plan until the next annual open enrollment period. The annual open enrollment period occurs between July 1 and July 31 of each year. At that time you may elect against Kaiser coverage and apply in writing for reimbursement for other coverage as provided for in this Summary Plan Description. In the event you or your spouse are covered only by another plan and you or your spouse lose that coverage through loss of employment you may enroll yourself and your spouse within 30 days of that event. This is called Special Enrollment.

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SOLANO-NAPA COUNTIES ELECTRICAL WORKERS HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION

ELIGIBILITY RULES

ACTIVE EMPLOYEE ELIGIBILITY

If you are an employee of a contributing employer for whom contributions are made to the Fund in accordance with a collective bargaining agreement you may become eligible for benefits in the manner described below.

Initial Eligibility

If you are a new employee of a contributing employer, you will become eligible on the first day of the second calendar month following a period not to exceed six months during which you have accumulated at least 125 hours in your hour bank. The maximum number of hours in your hour bank may not exceed 500 hours at any given time.

Example:

An employee begins work for a contributing employer on March 1. He works 100 hours in each of the first two months that follow. By the end of the second month (April), he has worked a total of 200 hours. He initially becomes eligible for benefits on June 1. Had he worked 125 hours or more in the month of March he would have obtained initial eligibility for benefits on May 1.

Continuation of Eligibility

To continue eligibility under the Fund, a charge of 125 hours per month will be made against your hour bank. The hours you work in one month will apply towards your eligibility for coverage in the second following calendar month. Consequently, if you continuously work 150 hours a month you will reserve 25 hours each month in your hour bank up to the maximum of 500 hours. If you do not work in a month, or if you work less than 125 hours in a month there will be a deduction of up to 125 hours per month from your hour bank to provide you coverage.

Example:

> The employee in the example above first became eligible for benefits on June 1 based on 200 hours worked through the end of April. He then worked 140 hours in May. For June coverage, he was charged 125 hours which were deducted from the April hour bank total of 200 hours. The May hours (140) are then added to the remaining 75 hours bringing the hour bank total to 215 which can then be applied towards the 125 hours required for July coverage.

Your eligibility for benefits depends on the continued and timely payment of employer contributions on your behalf. If your employer fails to make a contribution when it is due, your eligibility will terminate unless your reserve hour bank has sufficient hours to continue coverage. After eligibility is lost, it will be restored if and when the employer makes the required contribution. Work which provides the required contributions can be in the jurisdiction where IBEW Local 180 has a collective bargaining agreement with your employer or in another jurisdiction where another IBEW Local has a collective bargaining agreement with your employer **so long as you elect to reciprocate those contributions through the electronic ERTS system to the Plan**. ERTS elections are done online and can be done at any IBEW local union office.

Kaiser will only provide services and care to individuals who reside **or work** within the "service area".

Termination of Eligibility

Your eligibility for benefits will automatically terminate on the earliest of the following two dates:

- The last day of the calendar month in which you have less than 125 hours in your hour bank; or,

- The last day of the month following the date you enter full-time military service.

Example:

> In the case of the employee in the two previous examples, assume that he does not return to work after the month of May. By the end of June, he had 215 hours remaining in his hour bank. Following a deduction of 125 hours for July, he had 90 hours remaining in his hour bank. On this basis, he would not be eligible for coverage in August as he lacks the necessary 125 hours.

If eligibility is lost because you have insufficient hours in your hour bank, you may continue your coverage by self-payment as provided in the following paragraphs or you may be entitled to COBRA continuation coverage as described on page 6. You may also chose to exercise your COBRA rights after exhausting your rights to self-payment under the following paragraphs. Once a participant loses eligibility and fails to regain it for a period of twelve (12) consecutive months hours remaining in the hour bank are cancelled.

Extension of Benefits by Self-Payment

If your eligibility terminates because of a lack of hours in your hour bank, you may make self-payments to extend your coverage for up to twelve months. Self payments are part of your COBRA coverage extension, not in addition to. The difference between the Plan's "self- payment" and "COBRA payment" is that if you are eligible for self payment the monthly charge is generally less than the monthly charge for COBRA payments which are 102% of the actual cost of coverage. Self payment months run against your COBRA coverage months and can never exceed COBRA coverage months, the number of which is described below. Self-payments can last up to twelve (12) months unless you are disabled. In that event they can last longer as discussed below. *Self payments were adopted by your Board of Trustees. They are not required by law.*

Unless you are disabled, you must be willing to accept covered employment by being available for work at the Local Union hiring hall through its normal work referral procedure to be eligible for self payments under this provision (you must be on the out of work list). In addition, your monthly payments must be continuous and received by the Fund Office **no later than the 20th of the month prior to the month for which coverage is desired**.

If you have exhausted your right to self-payment, you may still qualify for COBRA continuation coverage as described on page 6. **However, any self- payment period will run concurrently with a COBRA eligible period and continuation months cannot be used twice, once for self-payment and once for COBRA coverage.** COBRA payments, which begin after self-pay, continue coverage for 18, 29 or 36 months – **less the period for which self-payments were made** – depending upon the reason coverage was lost. See Page 6 for further explanation of your COBRA rights. COBRA is regulated by Federal law.

If you are unable to accept covered employment due to disability you may be eligible to make self payments for longer than twelve (12) months. For this extension of more than twelve (12) months of self payments to apply you must have 1) submitted a written application for Social Security Disability benefits and 2) made application to the Fund Office for this self payment extension within six calendar months of the onset of your disability. Your ability to make self payments beyond 12 months will terminate immediately 1) upon notification of denial of Social Security Disability benefits at the Reconsideration level, 2) if you appeal the Reconsideration, denial at the Hearing level or 3) your return to work, whichever is earliest.

Reinstatement of Eligibility

If your eligibility terminates due to an insufficient number of hours in your hour bank, it will be reinstated if you again satisfy the Initial Eligibility Rules described on page 6. If such reinstatement does not take place within twelve months of termination, any hours in your hour bank will be cancelled.

If your eligibility terminates due to your entrance into full-time military service, your coverage will be reinstated for an initial three month period on the day that you begin working for a contributing employer provided that you return to work within 90 days of your discharge date. However, if you fail to return to work within 90 days of your discharge, you will be required to reestablish eligibility in accordance with the Initial Eligibility Rules on page 6.

DEPENDENT ELIGIBILITY

Your eligible dependents are your lawful spouse (or domestic partner) and unmarried natural, step or lawfully adopted children under age 19. Domestic partner status shall require compliance with the domestic partner laws of your state of domicile. Your state of domicile shall be presumed to be California unless clear and convincing evidence to the contrary is provided. If Kaiser has a broader definition of the term "dependent" in its contracts with the Fund, then those contract provisions shall govern for purposes of interpreting who is entitled to medical coverage. For example, dependent children 19 but younger than age 24 who are full-time students at an accredited educational institution of higher learning are entitled to Kaiser coverage. Proof of enrollment must be submitted to the Fund Office. For dental coverage, the Fund's definitions control in all events. There may be instances, therefore, where a dependent is entitled to coverage for medical care but not for dental coverage.

Children age 19 or older prevented from self-sustaining employment due to a mental or physical handicap may also qualify as dependents, provided the disabling handicap arose before the child attained 19. Also, dependent children 19 but younger than age 24 who are full-time students at an accredited educational institution of higher learning are entitled to dental coverage. Proof of enrollment must be submitted to the Fund Office. All requirements are described in detail in a document entitled "Rules and Regulations Providing Dental Benefits for Eligible Active and Retired Employees" which is an appendix to the Second Revised Eligibility Rules. Dependents become eligible for coverage on the later of the following two dates:

- The date you become eligible for benefits; or

- The date when a person becomes your dependent through legal marriage, birth or adoption, as the case may be.

Remember, if you have a final decree of dissolution (divorce) entered or decree of separation your (former) spouse is no longer eligible for benefits. You must notify the Fund Office of the event. If you fail to do so and claims are paid you will responsible to reimburse the Plan for the claims paid after the decree has been entered.

Retirees and dependents of deceased pension-eligible employees will become eligible as provided on page 10.

IMPORTANT REMINDER

You must inform the Fund Office within 30 days of adding a new dependent. If you fail to notify the Fund Office within 30 days following the addition of a new dependent (including newborns), you will not be able to enroll the dependent in the plan until the next annual open enrollment period, which occurs between July 1 and July 31 of each year, effective August 1. This will result in a delay in eligibility for benefits.

Eligibility of a dependent of an active employee will terminate on the earlier of the following two dates:

- The date you lose eligibility or your death (however eligible dependents of pension-eligible employees may continue coverage under circumstances described on page 14); or

- The date the person fails to meet the Fund's definition of a "dependent" as described on page 8.

Generally, the termination of eligibility of a dependent of a retired employee follows the same rules. A dependent of a deceased pension-eligible employee whose eligibility for retiree health benefits was effective before February 1, 1999 will be entitled to continued coverage only during a period that ends 5 years from the date of the employee's death if death occurred prior to attaining age 62 unless certain service requirements are met. See page 13 for the rules regarding retiree eligibility of retirees with an effective date after February 1, 1999.

Remember: A dependent, just like an active, may be eligible to continue coverage that has been lost due to a qualifying event, under the provisions of COBRA. Be sure to carefully read COBRA provisions to determine eligibility rights and the length of time for which coverage can be extended.

Dependents with Dual Coverage

If your dependent is also eligible as an employee for medical or dental benefits under another health plan, that plan shall be primary over benefits provided by the Fund. If your dependent is a child entitled to coverage under two or more health plans, the plan covering the custodial parent whose birth falls earlier in the calendar year will be primary. Additional rules regarding the Fund's coordination of benefits provisions are contained in the document entitled Second Revised Eligibility Rules for the Solano-Napa Counties Electrical Workers Health and Welfare Fund (as amended).

"NON-BARGAINING" EMPLOYEE ELIGIBILITY

An Employer contributing to the trust for bargaining unit employees (active employees) may include, by executing a subscription agreement, non-bargaining employees subject to the following rules:

1. All such employees in this category (non-bargaining unit employees) except those working less than hundred hours per month must be covered.

2. Contributions must be received by the twentieth of the month prior to the month for which coverage is desired.

3. The Employer must agree to adopt this Plan and the Trust agreement under which it operates.

4. Employers electing to cover their non-bargaining unit employees must cover newly hired non-bargaining employees the first of the month following completion of 90 days of continuous full-time employment (100 hour per month employment).

5. Contributing Employers not electing to cover their non-bargaining employees initially may thereafter apply on each successive anniversary date of the Plan, which is February 1st of each year, to enroll their non-bargaining unit employees.

6. Non-bargaining unit employees do not have a reserve hour bank account accumulation.

7. The Trustees shall establish the monthly payment required for non-bargaining unit participants from time to time. The amount of this monthly payment may be obtained by contacting the administrator's office. All employers electing to have non-bargaining unit employees participate in this Health and Welfare Plan are required to specifically comply with the Plan rules concerning payroll audits, assessment of liquidated damages, and other costs if monthly contributions are not received on-time.

COBRA CONTINUATION COVERAGE

Qualifying Events

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), an employee and his eligible dependents are entitled to pay for a temporary extension of the Fund's health benefits under certain circumstances called "qualifying events." In order to receive this COBRA continuation coverage, you and your eligible dependents must file a timely application following the qualifying event and make monthly self-payments directly to the Fund Office. *COBRA is a Federal law requiring health coverage be offered to participants who otherwise lose coverage due to a "qualifying*

event."Qualifying events resulting in loss of health coverage allowing for COBRA continuation include 1) loss of work, 2) reduction in work hours, 3) divorce, 4) losing child dependent status due to age. You are responsible to pay the required premium if COBRA continuation coverage is elected. Remember: ***Your period of COBRA eligibility will be reduced by any period for which self-payments were made.***

If your health coverage terminates due to any of the qualifying events shown below, you and your eligible dependents may elect COBRA continuation coverage for the maximum continuation period listed:

TYPE OF BENEFITS

If you and/or your eligible dependents elect coverage under COBRA, you each have the choice of taking either "core" or "core plus non-core" benefits. These choices consist of the following health benefits:

- *Core Benefits* - Medical benefits only.

- *Core Plus Non-Core Benefits* - Medical and dental benefits.

For an additional charge and subject to certain notice requirements, the 18-month maximum continuation period shown in the table above may be extended for up to 29 months for any individual receiving a Social Security disability award with an effective date of up to 60 days following the time of the reduction or termination of employment. Notice of the disability award must be provided to the Fund Office within 60 days after it is issued and within the initial 18-month period of COBRA eligibility. The 11-month disability extension period will end if you and/or your spouse or dependent children are no longer disabled before the end of the disability extension period. If you are on extended COBRA coverage, you must notify the Fund Office within 30 days if you receive a determination from the Social Security Administration that you or your spouse or dependent children is no longer disabled. Contact the Fund Office for further details about this disability extension.

The maximum continuation period is 36 months, even if more than one event occurs, giving rise to COBRA continuation rights.

COBRA continuation coverage will end before the 18-month, 29-month, or 36-month continuation coverage period expires if :

- You or your dependents fail to pay the required contribution on time;

- You or your dependents become covered by another group health plan, unless the other plan has a legally enforceable exclusion or limitation for a pre-existing medical condition that will affect you or your dependents' coverage; You or your dependents become entitled to Medicare; Your employer ceases to maintain any health plan for active employees, or

  You or your dependents qualified for the 29-month maximum continuation period based on disability, but are no longer are disabled.

Continuation coverage will no longer be available under this Plan if this Plan terminates. If you elect to purchase continuation coverage, coverage for your eligible family members will continue automatically unless your spouse independently declines coverage. If you elect not tocontinue your coverage, your spouse and eligible dependent children still may do so. Anyone electing continuation coverage must pay for it.

Once the Fund Office is notified of a qualifying event, the office will send you information concerning your continuation options, including the necessary election forms. You will have 60 days from the later of the date of the qualifying event or when you receive notice from the Fund Office in which to make your election.

If you use the health care services under the Plan after a qualifying event has occurred but before you have made your election under COBRA and before you have paid for the coverage, the Trustees may treat you as if you had made a COBRA election, and may collect from you either the premium payment for the coverage or the cost of the health care services that you used (subject to reimbursement upon timely election and premium payment).

You have a maximum of 45 days from the date that you mail your election form to the Fund Office in which to submit your first payment. No premium will be required to be paid before the end of the 45-day period after your election. Your first payment must retroactively cover any period of time after the date that coverage was terminated. All subsequent payments are due on the 10th day of the month for which coverage is to be provided. If any subsequent monthly payment is not received by the Fund Office on or before the 30th day of the month for which coverage is to be provided, your coverage will be canceled and your right to continuation coverage will be permanently lost.

Cobra Premium

The Fund will set premium payments according to Federal law, which allows the premium to cover the full cost to the Plan plus 2 % for COBRA administrative expenses. The Fund may charge 150% of the full cost of the Plan for the additional 11 months of coverage provided to totally disabled employees or dependents. If the cost changes, the Fund will revise the charge you are required to pay. In addition, if the benefits change for active employees, your coverage will change as well.

COBRA premiums are due on the 1st of the month for which coverage is requested. There is a grace period for payment up to the 30th day of the month for which coverage is requested. If payment is not paid by the end of the grace period coverage will lapse and cannot be thereafter reinstated. Until payment is actually made each month there is no coverage so payment should be made before the 1st of the month to guarantee coverage notification is sent to your providers in a timely manner.

CONTINUATION COVERAGE DURING MILITARY SERVICE (USERRA)

In accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA")(38 U.S.C. § 4317), if you are on military leave you are entitled to continuation coverage rights similar to those described under COBRA. This continuation of health and welfare coverage applies to both you and your dependents. You or your dependent may elect continuation health and welfare coverage. The coverage will be limited to a term that ends on the earlier of twenty-four (24) months from the date military service begins or the date on which USERRA requires you to offer to return to civilian employment. That date as follows:

- If the period of military service is less than 31 days, you must return to civilian employment, and continuation coverage will end, by the beginning of the first regularly scheduled work period after the end of the last calendar day of duty. This period is extended by the time required to return home safely. If this is impossible or unreasonable, then you must return as soon as possible.

- If the period of service is 31 to 180 days, you must return to civilian employment, and continuation coverage will end, no later than 14 days after completion of your service. If this is impossible or unreasonable through no fault of yours, then you must return as soon as possible.

- If the period of service is 181 days or more, you must return to civilian employment, and continuation coverage will end, no later than 90 days after completion of your military service.

- If you suffer from a service-connected injury or illness; the deadlines for returning to work are extended for up to two years while you are hospitalized or convalescing.

If you are on military leave for less than 31 days, there will be no charge to you for your medical coverage. Otherwise, you and your, eligible dependents must file a timely application following the end of the initial 30 day period of military service, make monthly self-payments directly to the Fund Office, and notify the Fund Office and your employer that you are leaving work for a military service. Continuation coverage under USERRA will not terminate if you or your dependents become covered by another group health plan.

DUTY TO NOTIFY FUND OFFICE

In order to preserve your rights under COBRA and USERRA, you must meet certain notification, election, and payment deadline requirements.

Under COBRA, you or your dependent must inform the Fund Office within 60 days of a divorce, legal separation or loss of dependent status. The Fund Office will notify you of loss of coverage due to a reduction in hours or the expiration of extended coverage under the Fund's self-pay program, and your employer will provide notice for other qualifying events (the employee's death, termination of employment, reduction in hours, or Medicare becoming the employee's primary coverage). However, you are encouraged to inform the Fund Office of any qualifying event to best ensure prompt handling of your COBRA rights.

Further details of COBRA continuation coverage will be furnished to you or your dependents when the Fund Office receives notice that one of the qualifying events has occurred. Therefore, we urge employees and dependents to contact the Fund Office as soon as possible after one of those events.

ADDITIONAL CONTINUATION COVERAGE FOR INDIVIDUALS AGE 60 OR OLDER

If you are age 60 or older and worked five years before your employment terminated, you (and your spouse) may be eligible under California law for continuation coverage even after your federal COBRA continuation coverage ends. The extended coverage must be elected 30 days before your COBRA coverage terminates. This special coverage is not an obligation of the Plan, but is offered through Kaiser Foundation Health Plan and other medical carriers under their policies. To obtain further information, you should contact your medical carrier directly.

RETIRED EMPLOYEE ELIGIBILITY

If you are a retired employee under the Inside Construction Agreement, you may be eligible for benefits, provided you meet the requirements described below. The requirements vary depending upon when you retired. However, in all cases, you must not engage in employment of any kind for wages or profit in the electrical industry within the United States. In addition, if you do not enroll in a timely manner or if you allow your coverage to lapse prior to age 62, you may not re-enroll until age 62. **Retiree coverage is not a vested benefit. The Trustees have discretion to reduce or eliminate the benefits under this plan**.

You may not elect portions of benefit packages, except for COBRA coverage described later in this booklet. For example, unless COBRA rules apply, the Plan will not offer hospital-medical coverage without dental benefits as long as dental benefits are continued for other retirees. Once self-payments begin, they must be continuous and uninterrupted. If you (or your dependents) stop making payments, coverage will terminate. Coverage cannot be reinstated once it is terminated unless the retiree or dependent is Medicare-eligible and enrolls in a Medicare Risk program under the Plan. (This reinstatement is only to the extent permitted by the service agreement with the Plan's provider.)

Initial Eligibility

If you retire on or after February 1, 1999, you may be eligible for benefits provided:

- You have attained age 55 or are currently receiving a Social Security Disability Retirement benefit based on total and permanent disability;

- You are receiving a pension under the Solano-Napa Counties Electrical Workers pension plan;

- You earned 120 calendar months of eligibility within 180 calendar months immediately prior to your effective date of eligibility of which 24 months were within the 60 months immediately preceding retirement; and

- You make the required self-payment contribution.

If you retired prior to February 1, 1999, or became eligible for this coverage as a dependent prior to February 1, 1999, the eligibility and coverage rules are different than those stated above. These rules will vary depending upon your date of retirement and are outlined in a document entitled "Second Revised Eligibility Rules for the Solano-Napa Counties Electrical Workers Health and Welfare Trust Plan" (as amended).

You must apply for retiree benefits within 90 days following the date on which you satisfy the requirements described above. Upon meeting the requirements, you will be eligible for coverage on the latest of the following dates:

- The first day of the month coinciding with your annuity starting date under the Solano-Napa Counties Electrical Workers Pension Trust Fund; or

- The first day of the month following the date in which you submit a Social Security Disability Award letter; or

- The date that your eligibility as an active employee terminates; or

- The first day of the month following the month in which your application for benefits is submitted to the Fund.

Retired Employee Contributions

You are required to make self-payments to the Fund in order to maintain coverage on behalf of yourself and your dependents. Different self-payment rates apply to retired employees who are not eligible for Medicare and their dependents, disability retirees, and Medicare-eligible retired employees and their dependents. **The self-payment rates are set by the Board of Trustees and subject to change from time to time. The Trustee reserve the rate to change the rates in their discretion and to discontinue any subsidy that the Plan otherwise provides. This subsidy is being reduced annually.**

ENROLLMENT FOR MEDICARE – RETIREES

Medicare benefits are not automatic; you must apply for them in order to be covered. Medicare benefits are available with two part coverage: Part A is free of charge and provides hospital benefits; Part B provides supplemental medical insurance and you are charged a monthly premium. Part D provide prescription drug coverage. You must enroll in Part B to be eligible for Part D coverage. The Fund coordinates benefits with Medicare as if you are covered under Part A, Part B and Part D. This means you must enroll in Medicare for both Part A, Part B and Part D as soon as you are eligible and assign the benefits to either the Fund or your HMO. **If you do not enroll in Medicare (Part A, Part B, and Part D), the Fund will not cover the portion of the expenses that Medicare would have paid.**

Medicare is primary coverage for retirees. Plan benefits are secondary. This means that the Plan pays only what Medicare does not cover. Therefore, failure to apply for Medicare will significantly reduce the total amount paid towards your medical expenses.

Termination Of Retiree Eligibility

Your eligibility for benefits will terminate if -

Your right to a pension from the Pension Trust Fund is terminated or suspended, or if you retired prior to July 23, 1981, you engage in employment of any kind for wages or profit in the electrical industry in the United States; or

You fail to make the self-payment described above.

Eligibility Of Dependents Of Retirees

Your eligible dependents are your legal spouse (provided you were married throughout the one year period immediately preceding your effective date of eligibility for retiree benefits) and dependent children. Your dependents become eligible on the effective date of your eligibility. Your dependents' coverage will terminate under any of the following circumstances:

The date your eligibility terminates for reasons other than by death; or

The date your dependent ceases to be a dependent.

Special provisions governing the eligibility of surviving dependents of deceased retired employees are described on the page below.

Out-of-area Retired Employee Medical Coverage

Kaiser Foundation Health Plan only provides services and care to individuals who reside within its "service area." Following your retirement, you may choose to live outside of Kaiser's service area. Although eligible for benefits, you will not be entitled to receive services from Kaiser.

If you reside outside of Kaiser's service area, you may purchase medical coverage from a health insurance carrier of your choice. The Fund will reimburse you up to a maximum amount which is determined by resolution of the Board of Trustees and is subject to periodic change. Generally, the rate corresponds to the monthly premium charged for "service area" retirees by Kaiser Foundation Health Plan. You must provide proof of coverage and payment in order to receive reimbursement. Reimbursement will be made only on a quarterly basis, to cover a maximum of three months of premium payments at one time, even if the premium paid by you is for a different term.

For further details concerning this program, contact the Fund Office.

Annual Certification

Once a year, you and/or your dependents must certify in writing that you/they remain eligible for retired employee benefits. You will be asked to verify that you have either remained unemployed or, if not, that you are not employed anywhere in the electrical industry in the United States. If you retired due to disability, you will be asked for evidence that you are still entitled to a Social Security Disability Retirement Benefit. If you and/or your dependents are Medicare eligible, you will be asked to show evidence of continuing Medicare eligibility. A dependent widowed spouse will be asked whether the spouse has remarried.

Forms will be sent to you by the Fund Office. Failure to complete and return the forms may result in the suspension or loss of benefits.

Surviving Dependent Eligibility

Surviving dependents (spouse and children) of deceased retired employees, deceased disability retirees, deceased pension-eligible employees, or deceased COBRA-eligible employees are eligible for continued coverage. Only surviving dependents of employees who worked under the Inside Construction Agreement may be eligible.

A "pension-eligible" employee is a person who is (1) eligible for a deferred vested pension under the Solano-Napa Counties Electrical Workers Pension Trust Fund, but has not yet retired; and (2) who has earned at least ten years of credited service under the Pension Plan, excluding any years earned prior to a permanent break in service.

A "COBRA-eligible" employee is a person who is receiving benefits under the Plan as an active employee or dependent on the day before a qualifying event occurs under COBRA. Qualifying events are described in this booklet. With limited exceptions described in the Second Revised Eligibility Rules a dependent born to or adopted by an employee while a period of COBRA continuation coverage is in effect will also be covered.

There will be a grace period during which self-payments will not be required. The grace period will extend for a period of six months following a retired employee's death or, in the case of a deceased pension-eligible employee or deceased COBRA-eligible employee, the six months following the date the employee's hour bank has less than 125 hours left. Thereafter, payment must be made until the surviving dependent becomes eligible for Medicare or enrolls in a Medicare Risk program.

Application must be made within 90 days following the employee's death. Payments are due by the 20th of the month preceding the month for which coverage is desired. Failure to make a timely self-payment will result in the termination of coverage for all dependents.

The eligibility of a surviving dependent of a pension-eligible or retired employee will terminate on the earliest of the following dates:

For a surviving spouse, on the date he or she remarries;

For a non-spousal dependent, on the date he or she ceases to meet the Fund's definition of a "dependent."

For all dependents, the failure to make a timely self-payment.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Health Insurance Portability and Accountability Act (HIPAA)

The Plan and any Business Associate as defined below will disclose Protected Health Information (PHI) to the Board of Trustees only to permit the Board of Trustees to carry out plan administration functions for the plan not inconsistent with the requirements of the Health Insurance

Portability and Accountability Act of 1996 and its implementing regulations (45 CFR §§ 160-64). Plan administration functions include treatment, payment and health care operations in connection with health benefits provided to you. Any disclosure to and use by the Board of Trustees of your PHI will be subject to and consistent with this section.

Restrictions on Use and Disclosure of Protected Health Information:

- The Board of Trustees will not disclose PHI except as permitted or required by the notice of privacy and the privacy rule, as amended, or required by law.

- The Board of Trustees will ensure that any agent, including any subcontractor, to whom it provides your Protected Health Information for purposes of treatment, payment or health care operations, agrees to the restrictions and conditions of the plan documents, including this section, with respect to your PHI. These subcontractors are call Business Associates.

- The Board of Trustees will not use or disclose PHI for employment related actions or decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees.

- The Board of Trustees will report to the Plan any use or disclosure of your Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

- The Board of Trustees will make PHI available to the Plan Participant is the subject of the information in accordance with 45 CFR §164.524.

- The Board of Trustees will make your PHI available for amendment in accordance with 45 CFR §164.526.

- The Board of Trustees will track disclosures it may make of your Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR §164.528.

- The Board of Trustees will make its internal practices, books, and records, relating to its use and disclosures of PHI available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with the law.

- The Board of Trustees will, if feasible, return or destroy all your PHI, in whatever form or medium (including any electronic media under the Board of Trustees' custody or control) received from the Plan, including all copies of any data or compilations derived from allowing identification of any participant who is the subject of the PHI, when your Protected Health Information is no longer needed for the Plan administration functions for which disclosures were made. If it is not feasible to return or destroy all your Protected Health Information, the Board of Trustees will limit the use or disclosure of any of your PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of information infeasible.

Authorization

Authorization is required for the use and disclosure of your protected Health Information for purposes other than permitted uses and disclosures specified in the privacy rule. If your authorization is needed you'll be asked to fill out an authorization form. The signing of the form is completely voluntary, and once signed, may be revoked in writing at any time.

HIPAA CERTIFICATION OF COVERAGE

(Limits of pre-existing condition exclusions)

If you or your dependent lose coverage under the Plan, you will be furnished with a certificate of former plan coverage. The certificate of former group health plan coverage provides evidence of your health coverage under the Plan.

If you become covered under a new group health plan that excludes coverage for certain medical conditions, you may need to furnish the certificate to the new plan administrator. Under a federal law known as the Health Insurance Portability and Accountability Act of 1996, or HIPAA, when you change health plans due to a change in employment, your prior creditable service under the Plan can be applied to reduce the period during which your new employer's plan, or a family member's employment-based health plan, can exclude coverage for medical conditions for which you were treated during the prior six months, but you will need the certificate of former coverage to take advantage of these rights. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage stops. You may also request a certificate within 24 months after losing coverage by contacting the Fund Office.

INDIVIDUAL CONVERSION COVERAGE FOR MEDICAL BENEFITS

If you and/or an eligible dependent cease to be eligible for benefits under the Plan, you may apply to your medical carrier for conversion of your group coverage to an individual policy. You may elect this option instead of the Fund's COBRA program. In addition, if your coverage under COBRA is terminated, you may apply for individual conversion at that time.

You should read the material that you receive from your medical carrier very carefully. In many cases, the coverage is not identical to that which you had while a Fund participant. Benefits are usually provided at lower levels than those found in group policies and premiums may be higher. However, conversion to an individual policy permits a person to maintain coverage without having to undergo a physical examination or providing proof of "good" health. In order to take advantage of the individual conversion option, you must notify the Fund Office or your medical carrier as soon as possible following your loss of eligibility. **You must submit your conversion application and initial premium within 31 days from your loss of eligibility.**

TERMINATION FOR CAUSE

The Fund is not responsible for maintaining the relationship between you and your chosen health care provider. Agreements between the Fund and its participating providers may permit the provider to terminate your coverage in cases where you fail to establish or maintain a satisfactory physician- patient relationship, provide incorrect or incomplete information, or, misuse any identification card. Such termination may result in your being unable to obtain coverage from any of the Fund's other participating providers. In such cases, the following rules shall apply:

- If you are unable to obtain coverage under any of the service agreements maintained between the Fund and its participating providers, you will be permitted to apply for reimbursement, in an amount determined by the Board of Trustees, for premiums paid for medical and/or dental coverage on an individual basis. Reimbursement shall not be available if only a dependent is terminated.

- The amount of reimbursement may include a deduction for administrative costs.

- Reimbursement shall be made on a periodic basis but no less than quarterly.

- The Fund shall require proof of payment and coverage as a condition for reimbursement.

The Fund may require that you enroll in one of its participating provider's plans if coverage becomes available to you following your termination for cause - even if you have already paid for alternative coverage.

The Trustees, in an effort to maintain the integrity of the Fund and/or protect its financial assets, may establish rules to preclude coverage of any kind, including reimbursement, if you abuse the provisions of this section.

EXTENDED COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT

Your employer must continue to pay for your health coverage during any approved leave under the federal Family and Medical Leave Act (FMLA). The Plan will subsidy this payment. In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year (and continuation health coverage) if:

- Your employer has at least 50 employees;
- You worked for the employer for at least 12 months and for a total of at least 1250 hours during the most recent 12 months; and
- You require leave for one of the following reasons:

(a) Birth or placement of a child for adoption or foster care,

(b) To care for your child, spouse or parent with a serious medical condition, or

(c) Your own serious health condition.

Details concerning FMLA leave are available from your employer. Requests for FMLA leave must be directed to your employer. The Plan cannot determine whether or not you qualify. However, if your employer certifies your eligibility for FMLA health care continuation the Plan will provide you continuation at no cost to you or your employer during your qualified FMLA period. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments. You may wish to contact the Employment Standards Administration, U.S. Department of Labor, concerning your rights. The Secretary of Labor may file suit to insure compliance and recover damages if a complaint cannot be resolved administratively. You may also have a private right of action without involvement of the Department of Labor to correct violations and recover damages through the courts.

If the dispute is resolved in your favor, the Plan will accept the FMLA-required contributions from your employer and will refund the corresponding COBRA payments to you. The Trust will not, however, pursue claims under the FMLA for plan participants or beneficiaries.

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

Rules and Procedures For Administering QMCSOs

Federal law provides specific rules under which group health care plans are required to provide medical benefits to a child of a participant under a state domestic relations law or state law relating to medical child support. A court or state administrative agency may issue a Qualified Medical Child Support Order (QMCSO) that requires a group health care plan to provide medical benefits to a participant's child.

The Plan will comply with any medical child support order which is "qualified" under federal law, as determined by the Board of Trustees. However, no such order, assignment or claim may require the Plan to provide benefits to someone not eligible under the rules of the Plan or to provide benefits in excess of the amounts stated in the applicable description of benefits. Pursuant to ERISA alternate recipients of Plan benefits under QMCSOs are generally considered plan beneficiaries. For purposes of ERISA reporting and disclosure requirements, alternate recipients under any medical child support order, whether qualified or not, are treated as participants under the plan.

QMCSO Requirements – Required provisions

A medical child support order is qualified if it 1) creates or recognizes an alternate recipient's right to receive benefits for which a participant or beneficiary is eligible to receive under a group health plan, or 2) assigns to an alternate recipient the right to receive such benefits. In addition, for an order to be a QMCSO it must clearly specify the following information:

- Name and last known mailing address of the participant and of each alternate recipient covered by the Order,

- Reasonable description of the type of coverage the plan is to provide to each alternate recipient or the manner in which the coverage is to be determined;

- Period to which the QMCSO applies.

Prohibited Provisions

The order will fail to be a QMCSO if it requires the plan to provide any type or form of benefit, or any option not otherwise provided under the plan, except to the extent necessary to meet the requirements of a state law relating to medical child support.

Procedure for Handling Court Orders

A group health plan must establish reasonable written procedures to determine whether a medical child support order is qualified and to administer the provision of benefits under a qualified order.

Establishment of Procedures for Determining Qualified Status of Orders

The Trustees established reasonable procedures to determine whether a medical child support order is qualified and administer the provision of benefits under such qualified order. These procedures, reproduced here, provide for the notification of each person specified in a medical child support order as eligible to receive benefits under the Plan promptly upon receipt by the Plan of the medical child support order, and permit an alternate recipient to designate a representative for receipt of copies of notices sent to the alternate recipient.

Review by Fund Office and Plan Counsel

The Plan, through its Plan counsel, reviews all court orders potentially affecting health care benefits to determine whether they meet the requirements above for acceptance as a QMCSO. Trust counsel, in consultation with the Fund Manager, makes a recommendation to the Board of Trustees whether an order meets the applicable requirements.Notices to Participant and Alternate Recipient.

Notice to Participant and Alternate Recipient

Within a reasonable period after receipt of a medical child support order creating rights for an alternate recipient, the Plan shall notify the participant and the alternate recipient of the order and the Plan's procedures for determining whether the order is qualified. The Board of Trustees will determine, within a reasonable time after receipt of any such order, whether the order is a QMCSO and will notify the participant and the alternate recipient

Limited Purpose of Plan's Review of Order

The Plan does not review child medical support orders to determine whether they are fair or complete, or whether they comply with applicable state law. The Plan looks only to see whether an order contains language about medical benefits which creates or recognizes the existence of an alternate recipient's right to receive benefits payable by this Plan.

PROCEDURE FOR HANDLING PROPOSED ORDERS OR INQUIRIES

Written Request for Information

Inquiries concerning the potential benefits of an alternate recipient should be made in writing to the Fund Office. Individual benefit information cannot be released to anyone other than the participant without either the participant's written consent or a subpoena.

Joinders, Proposed Court Orders, Subpoenas, other Communications

The Fund Office will promptly forward to Plan counsel any communications involving attorneys, including joinder requests, proposed orders, final orders, and any related correspondence or information relating a medical child support order. Plan counsel will also be responsible for subsequent communications with the participant and alternate recipient (or their attorneys) regarding the matter. If information about the participant's interest in the Plan has not previously been provided, Plan counsel will furnish the participant with such information as well as general information on the Plan, will file an appropriate response to any pleadings on joinder, and will review draft orders submitted by the parties and inform them whether the draft can be accepted as a QMCSO.

Plan Counsel will also provide participants and beneficiaries with these procedures and a sample QMCSO. Participants are not required to use the sample order. The sample order is simply to assist attorneys in understanding the Plan and to expedite the preparation of a QMCSO. The Plan does not warrant that the sample order is appropriate in each instance.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or

96 hours as applicable). In any case, plans and issuers may not require, under Federal law, that a provider obtain authorization from the Plan or the insurance issuer for prescribing a. length of stay not in excess of 48 hours (or 96 hours).

WOMENS' HEALTH AND CANCER RIGHTS ACT OF 1998

Your Plan, as required by the women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, (including lymphedema). If a participant or dependent is receiving benefits under the Plan through one of the Plan's medical carriers in connection with a mastectomy, and a participant or dependent elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy was performed;

- Surgery and- reconstruction of the other breast to produce a symmetrical appearance; and

Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

GENERAL INFORMATION ABOUT THE PLAN

You Must File An Enrollment Form

It is important that the Fund Office have a completed enrollment form for you on file, since that is the basis against which the Fund verifies medical and dental eligibility of your and your dependents. This form is also necessary to designate your beneficiary for the life and accidental death and dismemberment insurance. Blank enrollment forms can be obtained from the Business office of IBEW Local 180 and from the Fund office.

REMEMBER:

Plan benefits are not guaranteed. The Trustees reserve the right to change or discontinue (1) the types and amount of benefits under this plan, and (2) the eligibility requirements for such benefits. The nature and amounts of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim was incurred and all interpretations regarding eligibility and amount of benefits is discretionary with the Board of Trustees or its authorized agent.

Kaiser Coverage for You and Your Eligible Dependents

The Plan, through employer contributions, pays insurance premiums for health benefits through Kaiser Foundation Health Plan. Kaiser Foundation Health Plan's benefits are briefly described below. However, a more detailed explanation along with a description of the benefits is provided in a separate brochure. Steps to be taken in the event Kaiser denies a claim are described below under the section entitled Claim and Appeal Procedures.

Waive of Kaiser Coverage (Self Procured Coverage)

An employee may, during open enrollment or any period of Special Enrollment elect to waive Kaiser coverage under the Plan and instead elect to obtain their own coverage and be reimbursed by the Plan in an amount which is the lesser of the cost of the Kaiser premium or the actual cost of the coverage obtained by the participant.

Waiver of Plan coverage must be in writing signed by the participant and spouse, if any, on a form provided by the Plan. Once coverage has been waived it can only be elected again during open enrollment. If a participant has waived coverage and thereafter loses alternate coverage said loss of coverage will not be considered a "qualifying event" under COBRA. Therefore, COBRA continuation rights under the Plan will not be available. The Plan will be held harmless from any liability incurred as a result of the need for medical treatment required or incurred by the participant and his or her dependents, if any, while on self procured coverage.

Active and retired employees who wish to change from Kaiser to Self-Procured Coverage may do so on an annual basis during the enrollment period between July 1 and July 31 by submitting a waiver of coverage form as described above to the Fund Office indicating the change. The change will go into effect on August 1 of that year. If you move out of the service area and cease working in the service area of Kaiser between enrollment periods, you may change to Self Procured Coverage, provided you complete and submit a waiver of coverage form to the Fund Office.

KAISER PERMANENTE PRE-PAID MEDICAL PLAN

Kaiser Foundation Health Plan
1800 Harrison Street, 9th Floor
Oakland, CA 94612-3412

When you enroll in the Kaiser Foundation Health Plan, you must receive all your medical care and prescription drug services at Kaiser Permanente facilities and contracting facilities. Services that are prescribed or directed by a Kaiser Permanente physician are provided subject to any co-payments required by the Plan. Kaiser Foundation Health Plan will reimburse you for services received from non-Kaiser physicians or facilities only as described in the Kaiser brochure.

Kaiser Health Plan brochures are available from the Fund Office that will provide you with a full description of the Kaiser Health Plan benefits, exclusions and limitations. A listing of Kaiser medical offices and hospitals is also available. The Fund delegates to Kaiser the discretionary authority to administer claims and determine eligibility for benefits.

Kaiser Foundation Health Plan Denials

Any denial of a claim for medical benefits will be explained to you in writing by Kaiser Foundation Health Plan. The explanation will include specific reasons for the denial, reference to the Plan or policy provisions on which the denial was based, a description of any additional material or

information you may need to provide, and the reason why such material or information is needed. You will also receive an explanation of the claims appeal procedure.

If you do not agree with the reasons for the denial of your claim, you may request reconsideration of the decision by filing an appeal. Your appeal must be in writing and should include documents or records in support of your request. Your appeal should be sent directly tothe provider that rejected your claim:

Kaiser Foundation Health Plan, Inc.
P.O. Box 12916
Oakland, CA 94604

The California Department of Managed Health Care (DMHC) requires that Kaiser advise you of the following, which has been reprinted for your convenience:

The California Department of Manager Care is responsible for regulating Health Care Service Plans. The Department has a toll-free telephone number (1-800-400-0815) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free numbers (1-800-735-2929 (7TY) or 1-888-877-5378 (TM) to contact the Department. The Department's Internet website (http://www.dmhc.ca. gov) has complaint forms and instructions online. If you have a grievance against Kaiser, you should first telephone Kaiser, 1800-464-4000 and use Kaiser's process before contacting the Department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Kaiser, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. Kaiser's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

EMPLOYEE LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (Available to Active Electrical Workers Only– No Dependent, COBRA or Retiree Coverage)

The Solano-Napa Counties Electrical Workers Health and Welfare Trust Fund has established an agreement with Standard. Insurance Company to provide you with life insurance and accidental death and dismemberment insurance benefits.

The Fund contracts for administration (claims payment) of life and accidental death and dismemberment (AD&D) benefits with:

Standard Insurance Company
920 S.W. 6th Ave.
Portland, OR 97204

Life Insurance

In the event of your death from any cause, Life Insurance in the amount of $5,000 is payable to the beneficiary named by you on your enrollment form.

Accidental Death And Dismemberment

In the event you suffer the loss of a hand, foot or sight of an eye, as the result of an occupational or non-occupational accident, you will be paid accidental death and dismemberment insurance in the amount of $2,500 or $5,000 for both hands, both feet, sight of both eyes, or one hand and one foot, or either hand or foot and the sight of one eye. If you die as the result of an occupational or non-occupational accident, your beneficiary will be paid accidental death and dismemberment insurance in the amount of $5,000.

The benefit for loss of life is payable to your beneficiary. The benefit for any other loss is payable to you. Loss of hand or foot means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means entire irrevocable loss of sight.

Accidental Death and Dismemberment benefits will not be paid for any loss caused by war, suicide attempt or under certain other circumstances described in the booklet from Standard Insurance Company.

Seat Belt Benefit

An additional $5,000 will be payable if you die as the result of an automobile accident and you were wearing a seat belt at the time of the accident.

Waiver of Premium

In the event you become totally disabled as determined by Standard Insurance the requirement of a premium to continue coverage will be waived.

How to File a Claim

Life insurance will be paid upon receipt of a certified copy of the death certificate along with completed forms required by the insurance company. The Accidental Death and Dismemberment (AD &D) benefits will be paid as soon as the insurance company can verify proof of such loss. For details concerning applications for Life Insurance and AD &D Insurance, please call or write the Fund Office.

Information concerning these Accidental Death and Dismemberment benefits, the designation of beneficiaries, disability premium waivers and conversion privileges are explained in detail in the booklet from Standard Insurance.

DENTAL PLAN BENEFITS

The Fund provides coverage for dental examination and treatments performed by a licensed dentist or dental hygienist under the supervision of a dentist. The Plan will pay a percentage of the covered charges for the treatment, examination or procedure, but not more than the Reasonable Charges of the Plan. You will be responsible for the first $25 of Reasonable Charges for covered dental services for each member of your family in each calendar year. The maximum deductible for your family is $75 per calendar year.

Reasonable Charges

Reasonable Charges are defined by the Plan as charges made by a dentist for services, treatments or supplies which do not exceed the general level of charges made by other dentists rendering or furnishing such services, treatments or supplies within the area in which the charge is incurred for dental care comparable in severity and nature to the dental condition treated or being treated.

Plan Maximums

The maximum amount payable for all Dental Plan benefits is $3,000 for each eligible individual during a calendar year. The lifetime maximum amount payable for Orthodontic benefits is $1,500 for each eligible individual, where the maximum was exhausted prior to April 1, 1999. Otherwise, the lifetime maximum for Orthodontic benefits is $3,000 for each eligible individual. Other rules apply to individuals who exhausted their $1,500 lifetime maximum prior to April 1, 1999 but had orthodontia work in progress under a continuing treatment plan submitted as of May 1, 1999. If your orthodontic care began prior to April 1, 1999, you should refer to the Rules and Regulations.

How to File a Claim

- To file a claim, obtain a dental form from the Fund Office. Here are the important things to remember about filing your claim:

- Carefully fill out and sign your portion of the form and have your dentist complete his portion.

- Attach all bills relating to the claim and be sure they are itemized. Incomplete forms and unclear bills delay your payments.

Mail the completed claim form to the Fund Office (Solano -Napa Electrical Workers Health and Welfare Trust, P.O. Box 1306, San Ramon, CA 94583) along with the bills.

All claims should be filed within twelve (12) months from the date the expense was incurred. Failure to do so will result in non-payment

Pre-Treatment Review

If you or your covered dependent requires non-emergency dental services in excess of $500, you may request authorization from the Fund prior to receiving these services. This will enable you to budget any charges that are in excess of those covered by the Plan:

Have your dentist complete the "DENTIST" section of the dental claim form outlining the proposed course of treatment and charges. Your dentist should then forward the claim form with any X-rays prior to the commencement of the proposed treatment to the Fund Office.

You and your dentist will be notified promptly of the benefits that will be available under the Plan.

COVERED DENTAL SERVICES

Services	Percentage Payable of Reasonable Charges
I. Regular Dental	**90%**
II. Prosthodontics	**60%** The Plan provides payment of 60% of the Reasonable Charges for bridges, partial dentures and complete dentures, not more than once in every five-year period.
III. Orthodontics	**90%** The Plan provides payment of 90% of the Reasonable Charges for procedures using appliances or surgery to straighten or realign teeth, which would otherwise not function properly.

REGULAR DENTAL CARE

The Plan provides payment of 90% of the Reasonable Charges for the following services:

- Visits and consultations
  - Diagnostic procedures.

- Prophylaxis (cleaning) - two in a calendar year.

- Complete mouth X-rays every three years - supplementary bite-wings once in any six-month period.

- Oral Surgery
  - Provides for extractions and other dental surgery including pre-and post-operative care.

- Endodontics
  - Includes pulpal therapy and root canal filling.

- Periodontics
  - Includes procedures necessary for the treatment of diseases of the gum and bones supporting the teeth.

- Restorative Dentistry
  - Provides amalgam, synthetic porcelain and plastic restoration. Gold restorations, crowns and jackets are provided when teeth cannot be restored with a filling material.

- Implants
  - Implants (artificial materials implanted into or on bone or soft tissue), or the surgical removal of implants, are available to participants as an alternative treatment to bridgework and crowns or removable partial and full dentures. The Plan benefits for implants are the same as for the Plan benefits for Prosthodontics. Implants will be replaced only after five years have elapsed.

DENTAL SERVICES NOT COVERED

No payment will be made under this Plan for expenses incurred for any of the services listed below.

- Crowns, jackets and gold or cast restoration replaced prior to five (5) years having elapsed;

- Prosthodontics appliances, including fixed bridges, partial dentures or complete dentures, replaced prior to five years having elapsed;

- Services for injuries or conditions that are compensable under Workers' Compensation laws or similar legislation; services that are provided by or paid for by any governmental program national state, county or municipal;

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

- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons;
- Prescribed drugs, pre-medication or analgesia;
- Experimental procedures;
- All hospital costs and any additional fees charged by the Dentist for hospital treatment;
- Charges for anesthesia, other than general anesthesia administered by a licensed Dentist in connection with covered oral surgery services;
- Extra oral grafts (grafting of tissues from outside the mouth to oral tissues);
- Services with respect to any disturbance of the temporomandibular joint (jaw joint).
- Charges in excess of those determined to be Reasonable Charges;
- Conditions caused by or arising out of an act of war, armed invasion or aggression;
- A condition for which the eligible individual is not under the care of a dentist.

Any request for review by the Board or its designee should be sent to Solano-Napa Counties Electrical Workers Health and Welfare Trust Fund, P.O. Box 1306, San Ramon, CA 94583.

COORDINATION OF BENEFITS
(WHEN BENEFITS ARE PAYABLE UNDER MORE THAN ONE GROUP PLAN)

If you or your eligible dependents are also covered by another group plan, the benefits payable by the Health and Welfare Fund for dental care expenses may be adjusted. This Plan will work together with any other plan under which you may have coverage, enabling you to receive the full amount of dental benefits to which you are entitled under both Plans. In other words, by "coordinating" the dental benefits of this Plan with the dental benefits of another plan, you may receive full payment of your dental expenses (but not more than 100% of the Plan's Reasonable Charges) rather than partial payment. This does not mean 100% of any charge, no matter how large, but up to 100% of the amount of the charge which the Plan defines as "Reasonable."

CLAIM AND APPEAL PROCEDURES

Eligibility and Dental Benefits Denials

All benefits will be paid in accordance with the terms of the Plan. On questions of eligibility and for benefit claims under the Dental Plan, the Trust will make a decision on your initial claim as follows:

Claim Type	Plan Must Make Decision Within:
Urgent Health Care	72 hours
Pre-Service Claims	15 days
Post-Service Claims	30 days
Disability Claims	45 days
Extensions for Pre- and Post-Service Claims	One 15 day extension for pre-and post-service claims under specified circumstances; 30 days for disability claims; notice requirements exist. Tolling provisions also exist if patient fails to provide certain information and receives notice of information needed.

If your claim for eligibility or dental benefits is denied either whole or in part, you will receive written notification from the Fund Office including the reasons for denial (where urgent care is involved an initial notice may be provided verbally within 72 hours with written confirmation furnished within three days after).

If you are not satisfied with the claim decision, you must submit a written request for review of the denial to the Board of Trustees, or its designee within 180 days from the day you received the denial. Any such request should include documents or records in support of your appeal. The decision of the Board or its designee as to any claim is final and binding, subject to such judicial review as provided by ERISA and the terms of this Plan. A written response to your appeal will be provided pursuant to the following time guideline:

Claim Type	Plan Must Make Decision Within:
Urgent Health Care	72 hours
Pre-Service Claim	30 days
Disability	45 days, or within 5 days following the next quarterly Trust meeting (or the second quarterly Trust meeting following the date of receipt if that day is less than 30 days prior to the quarterly meeting)
Post-service claims	60 days, or within 5 days following the next quarterly Trust meeting (or the second quarterly Trust meeting following the date of receipt if that day is less than 30 days prior to the quarterly meeting)

VERIFICATION AND PROOF

At the request of the Trustees you must furnish any information or proof reasonably required to determine your benefit rights under the Plan. If you willfully make any false statements or furnish any information or proof that is fraudulent, or if you fail to notify the Fund Office within 90 days after the loss of your or your dependent's eligibility under the Plan, your benefits under this Plan may be denied, suspended or terminated. In addition, the Trustees can demand a refund from you for any benefit payments or premium payments made prior to your notification to the Trustees, or made in reliance upon any false or fraudulent statement you have made.

RIGHTS AGAINST A THIRD PARTY

If you or your eligible dependents have an injury or an illness that is caused by a third party, this Plan will not cover the expenses of that injury or illness to the extent that such expenses have been, or may be, paid to you or your estate by the third party or its insurer. If benefits have been paid or services have been rendered to you under the Plan, and you are reimbursed by a third party or its insurer, the Plan is entitled to a refund from you of the amount of the benefits you received from the third party up to but not in excess of benefits received under the Plan. You must set aside monies recovered, keep them segregated and refund to the Plan (or its carrier) those monies. Such repayment will constitute restitution for funds advanced on your or your dependents' behalf. In addition, if the Plan (or its carrier) pays any expenses on your behalf for an injury or illness caused by a third party, you must assign to the Plan (or its carrier) your rights of action and recovery for those expenses against the third party or any other persons. Failure to reimburse will result in offsetting future benefits that may otherwise be due you or your dependents.

OTHER INFORMATION

The indemnity dental program is not insured by any contract of insurance, and there is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amount in the Trust Fund collected and available for such purpose.

Only a summary of the Fund's benefits appears on the previous pages. If you are eligible for the benefits of the Health and Welfare Plan, your rights can only be determined by reading the complete Rules and Regulations of the Plan.

Plan benefits are not guaranteed. The Trustees reserve the right to change or discontinue (1) the types and amount of benefits under this Plan, and (2) the eligibility requirements for such benefits. The nature and amounts of Plan benefits are always subject to the actual terms of the Plan interpreted by the Trustees under their discretion and as the Plan existed at the time the claim was incurred.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Solano-Napa Counties Electrical Workers Health and Welfare Plan Fund

This information applies to the Solano-Napa Counties Electrical Workers Health and Welfare Plan.

1. The name of the Plan is:

   Solano-Napa Counties Electrical Workers Health and Welfare Plan

2. Name, address, and telephone number of the Boards of Trustees:

   BOARD OF TRUSTEES
   Solano-Napa Counties Electrical Workers Health and Welfare Trust Fund or
   Solano-Napa Counties Electrical Workers VEBA

   P.O. Box 1306
   San Ramon, California 94583
   (925) 208-9980

3. The Employer Identification Number (EIN) issued to the Board of Trustees for the Solano-Napa Counties Electrical Workers Health and Welfare Trust Fund by the Internal Revenue Service is: 94-6085742

4. The Plan Year is the twelve-month period beginning each February 1st and ending on the following January 31st.

5. The Health and Welfare Plan provides life insurance, accidental death and dismemberment insurance to eligible employees, and hospital, medical and dental benefits to eligible employees and their dependents.

6. The person designated as agent for the service of legal process is:

   Mark Lipton
   1380 Lead Hill Blvd., Ste. 106
   Roseville, CA 945661

   Service of legal process may be made upon a Plan Trustee or the Board of Trustees at the address shown above.

7. The names and addresses of the Trustees are listed below:

Employer Trustees

Don Campbell
Northern California Chapter, NECA
6300 Village Parkway
Dublin, CA 94568

Randy Baracosa
c/o Northern California Chapter, NECA
6300 Village Parkway
Dublin, CA 94568

Jess Zuniga
c/o Zeco Electric
P.O. Box 4110
Vacaville, CA 94558

Ruben Perez
c/o Napa Electric
P.O. Box 818
Napa, CA 94559

Greg Armstrong
c/o Northern California Chapter, NECA
6300 Village Parkway
Dublin, CA 94568

Union Trustees

Dan Broadwater
c/o IBEW Local 180
720B Technology Way
Napa, CA 94558

Stan Nelson
c/o IBEW Local 180
720B Technology Way
Napa, CA 94558

Gary McCoy
c/o IBEW Local 180
720B Technology Way
Napa, CA 94558

Richard Mattson
c/o IBEW Local 180
720B Technology Way
Napa, CA 94558

8. Plan Administrator: The Board of Trustees is the Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to government agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974.

   The Board of Trustees has contracted with a third party administrator to provide routine administrative services to the Plans.

9. Availability of Collective Bargaining Agreements: The Plans are maintained pursuant to collective bargaining agreements. A copy of the collective bargaining agreements is available for examination and may be obtained upon request to the Fund office.

10. Source of contributions: Contributions to provide benefits from both Plans are paid by the contributing employers in accordance with their bargaining agreements, at a fixed hourly rate.

    The Fund office will provide you, upon written request, information as to whether a particular employer is contributing to the Plans on behalf of participants working under the collective bargaining agreement and, if the particular employer is contributing to the Plans, the employer's address.

11. The Plan's benefits are financed through employer contributions.

    Benefits are provided from a trust fund and insurance contracts through Standard Life Insurance Company, Kaiser Foundation Health Plan.

12. The Plans' assets and reserves are currently invested by the Trustees.

Statement Of Erisa Rights

As a participant in the Solano-Napa Counties Electrical Workers Health & Welfare Trust Fund and the Solano-Napa Counties Electrical Workers VEBA 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:

Receive Information About Your Plan And Benefits

Examine, without charge, at the Fund Office at 2610 Crow Canyon Road, Ste. 200, San Ramon, CA 94583 and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration. To obtain, from the Fund office, upon

written request, 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. Reasonable charges for the copies may be required.

Receive a summary of the Plan's annual financial report. The law requires the Fund to furnish each participant with a copy of this summary annual report.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to receive a written explanation of why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive 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. 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 domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

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

Benefits Security 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 Employee Benefits Security Administration.

THIRD REVISED ELIGIBILITY RULES
FOR THE
SOLANO-NAPA COUNTIES ELECTRICAL WORKERS
HEALTH & WELFARE PLAN
(Revised and restated July 1, 2004)

INDEX

SOLANO-NAPA COUNTIES ELECTRICAL WORKERS HEALTH AND WELFARE PLAN

THIRD REVISED ELIGIBILITY RULES
FOR THE
SOLANO-NAPA COUNTIES ELECTRICAL WORKERS
HEALTH & WELFARE PLAN
(Revised and restated July 1, 2004)

Effective July 1, 2004, unless otherwise stated herein, the following Third Revised Eligibility Rules for the Solano-Napa Counties Electrical Workers Health and Welfare Plan are adopted. This is a collectively bargained Health and Welfare Plan. It is governed under the terms of a Trust Agreement for the Solano-Napa Counties Electrical Workers Health & Welfare Trust. The terms of the Trust Agreement are the subject of good faith bargaining between the Union and the Association, and all contributions to the Health and Welfare Plan are made pursuant to collective bargaining agreements or the Electrical Industry Health and Welfare Reciprocal Agreement (Appendix B), except as the Trust Agreement or the Eligibility Rules permit contributions pursuant to a Subscription Agreement.

ARTICLE 1 DEFINITIONS

Section 1.1 Active Employee

"Active Employee" means any person who meets the eligibility rules in paragraph 2.1(a) and (b) and has not suffered termination of eligibility under paragraph 2.1(c).

Section 1.2 Association

"Association" means the National Electrical Contractors Association.

Section 1.3 Board of Trustees or Trustees

"Board of Trustees" or "Trustees" means the Board of Trustees established by the Trust Agreement.

Section 1.4 Child or Children

"Child" or "Children" means an Employee's natural or lawfully adopted children, except that the natural children of a male Employee who are not the issue of a legal marriage will be covered only upon legal adoption by the Employee or when the Employee becomes the court-appointed legal guardian unless a broader definition is provided in any contract of insurance or for health care services executed by the Fund. Provided, that where offered and permitted under a contract of insurance or for health care services, "Child" or "Children" also shall mean the natural or legally adopted child of an employee's lawful spouse.

Section 1.5 COBRA-Qualified Employee

"COBRA-Qualified Employee" means any Active Employee who is a Qualified Beneficiary under paragraph 2.4(c).

Section 1.6 Dependent

"Dependent" means:

(a) The legal spouse or domestic partner of an Active Employee, Retired Employee, deceased Pension-Eligible Employee, or commencing February 1, 2000, the spouse or domestic partner of a deceased COBRA-Qualified Employee; or

(b) Unmarried children of an Employee, if they are:

(1) younger than 19 years of age;

(2) age 19 or older, but younger than age 24, and full-time students at an accredited educational institution; or

(3) age 19 or older and prevented from self-sustaining employment due to a mental or physical handicap, provided the disabling handicap arose before the child attained 19. For dental coverage, certification of the disability from the Dependent's health care services provider shall be provided to the Fund Manager as requested.

By adopting a more inclusive definition of "Dependent" in any contract of insurance or for health care services executed by the Fund, the Fund does not waive its right to apply the definition of this Section 1.6 under any other contract or plan of benefits, and the Fund may continue to do so notwithstanding the terms of any other such contract. "Dependency" by virtue of domestic partner status shall require compliance with the domestic partner laws of the state of domicile of the plan participant. California will be presumed to be the state of domicile absent clear and convincing evidence to the contrary.

Section 1.7 Employee

"Employee" means each Active Employee and each Retired Employee.

Section 1.8 Employer or Contributing Employer

"Employer" or "Contributing Employer" means any association, individual, partnership, corporation or entity which employs Employees and is a party to the Labor Agreement with the Union. The term "Employer" may include the Association or the Union if the inclusion of the Association or the Union does not jeopardize the tax-exempt status of the Trust.

Section 1.9 Fund

"Fund" means the Solano-Napa Counties Electrical Workers Health and Welfare Trust Fund; the term "Fund" also means the Board of Trustees established by the Trust Agreement, where applicable. "Fund Office" means the office of the Fund Manager appointed by the Trustees to administer the Plan.

Section 1.10 Hour Bank

"Hour Bank" means the account established for an Active Employee to which is credited all hours worked for Contributing Employers and for which contributions are made. Credits to the "Hour Bank" shall be given only upon actual receipt of contributions for the hours worked. "Hours" credited to the Hour Bank shall be prorated to the extent that contributions received under Reciprocity Agreements are paid at rates less than the prevailing rate established for contributions to the Fund by the Labor Agreement between the Union and the Association.

Provided, that credits to the "Hour Bank" may be given upon receipt by the Fund of reliable evidence that an Active Employee performed work for which contributions were required to be made to the Fund but were not made. Credit will not be given where contributions are not received for work performed after the date on which the Fund notifies the Active Employee in person or in writing that the Employer is delinquent in its contributions. When such notice is mailed, it will be deemed received by the Employee on the fifth (5th) calendar day following deposit of the notice in the first class mail, posted to the most recent address of the Employee contained in the records of the Fund. Further, no person shall be entitled in any case to coverage for a period prior to the date in which his "Hour Bank" reflects credits sufficient to satisfy the eligibility requirements of Article 2.

Section 1.11 Labor Agreement

"Labor Agreement" means any collective bargaining agreement between the Union and any Employer, including any extension thereof or any new collective bargaining agreement which provides for contributions to the Trust.

Section 1.12 Pension Plan

"Pension Plan" means the Pension Plan for the Solano-Napa Counties Electrical Workers Pension Trust. "Pension Plan" does not mean the Solano-Napa Counties Electrical Workers 401(a) Plan unless otherwise specifically stated.

Section 1.13 Plan or Health & Welfare Plan

Unless otherwise indicated by the context, "Plan" or "Health & Welfare Plan" means the Solano-Napa Counties Electrical Workers Health & Welfare Plan.

Section 1.14 Reciprocity Agreements

"Reciprocity Agreements" means an agreement enabling participants of one health and welfare fund to accept temporary employment within the jurisdiction of another health and welfare fund while at the same time receiving and maintaining eligibility in the original fund through the transfer of employer contributions between participating funds. Reciprocity Agreement includes the Electrical Industry Health and Welfare Reciprocal Agreement

Section 1.15 Retired Employee or Retiree

"Retired Employee" or "Retiree" means any person who meets the eligibility rules of paragraph 2.2(b).

Section 1.16 Trust Agreement

"Trust Agreement" means the Trust Agreement establishing the Solano-Napa Counties Electrical Workers Health and Welfare Trust Fund and any modification, amendment, extension or renewal thereof.

Section 1.17 Union

"Union" means Local 180 of the International Brotherhood of Electrical Workers.

Section 1.18 Pension-Eligible Employee

"Pension-Eligible Employee" means any person who:

(a) Is eligible for a Deferred Vested Pension under the Pension Plan of the Solano-Napa Counties Electrical Workers Pension Trust Fund but for whom such a pension is not immediately payable; and

(b) Has at least five (5) years of credited service without a permanent break in service under the Pension Plan.

Section 1.19 Subscription Agreement

"Subscription Agreement" means an agreement between the Trustees and any Employer providing for contributions for all employees of the Employer not covered by a collective bargaining agreement.

Section 1.20 Other Terms

Other terms are specifically defined as follows:

Term	Paragraph(s)
COBRA	2.4(a)
Election Period	2.4(l)
Inside Construction Agreement	2.2(a)
Later-Acquired Dependents	2.2(c)(2)
Premium Due Date	2.4(j)
Qualified Beneficiary	2.4(c), 2.4(l)

ARTICLE 2 ELIGIBILITY

Section 2.1 Eligibility Rules for Active Employees

(a) Initial Eligibility

Except as otherwise provided by the pre-payment provisions of any Subscription Agreement, a person who is an Employee of a Contributing Employer with respect to whom contributions are made or are required to be made for the maintenance of this Health and Welfare Plan shall first become eligible for benefits on the first day of the second calendar month which follows a period of not fewer than two nor more than six consecutive calendar months during which he has accumulated 125 contributory hours in his Hour Bank. The maximum hours in an Active Employee's Hour Bank may not exceed 500.

(b) Continuation of Eligibility through Hour Bank

A charge of 125 hours per month for coverage shall be made against an Active Employee's Hour Bank. Hours worked in one month shall apply to coverage in the second following calendar month. Any Hours remaining in a former Active Employee's Hour Bank will be canceled if he loses eligibility and does not regain it within a period of twelve consecutive calendar months.

(c) Termination of Eligibility

An Active Employee's eligibility will terminate on the earlier of the following dates:

(1) On the last day of the calendar month on which he has fewer than 125 hours in his Hour Bank.

(2) On the last day of the month following entry into full-time military service.

(d) Return from Military Service

If an Active Employee's eligibility is terminated because of entry in the military service, his eligibility will be reinstated on the day he begins work with a Contributing Employer, provided he returns to work within ninety (90) days from the date of his discharge. His eligibility will continue for three consecutive calendar months. If he does not return to work to a Contributing Employer within ninety (90) days from the date of discharge, he must meet the initial eligibility requirements described in paragraph 2.1(a).

(e) Dependent's Eligibility

(1) **Effective Date of Dependent's Eligibility**. A Dependent's eligibility will become effective on the later of:

(A) The date the Active Employee becomes eligible; or

(B) The date the Employee acquires the Dependent, provided the Employee is eligible on that date, and provided that an application for enrollment of the Dependent

is made within ninety (90) days after the person qualifies as a Dependent. Otherwise, the Dependent will be eligible for enrollment only during an annual enrollment period.

(C) For a Dependent enrolled during an annual open enrollment period, the first day of the calendar month following open enrollment.

(D) Effective February 1, 1999, Retirees, their Dependents and surviving Dependents of deceased Pension-Eligible Employees will become eligible as provided in paragraphs 2.2(c)-(d) and Section 2.5.

(E) Effective February 1, 2000, surviving Dependents of deceased COBRA-Qualified Employees will become eligible as provided in paragraphs 2.2(c)-(d) and Section 2.5.

(2) **Termination of eligibility of Dependent of an Active Employee**. The eligibility of a Dependent of an Active Employee will terminate on the earlier of:

(A) The date the Active Employee ceases to be eligible; or

(B) The date the Dependent ceases to be a Dependent as defined in Section 1.6.

(3) **Effective Date of Surviving Dependents' Eligibility**. The surviving Dependents of a deceased Pension-Eligible Employee or a deceased Retiree will be eligible for continuation of coverage without contribution for a limited period as provided in Section 2.5. Commencing February 1, 2000, the surviving Dependents of a deceased COBRA-Qualified Employee will be eligible for continuation coverage for a limited period as provided in Section 2.5. To receive coverage, it will be necessary for surviving Dependents of a deceased Pension Eligible Employee, a deceased Retiree, or a deceased COBRA-Qualified Employee to make the application required by paragraph 2.2(d) and to make the payments required by Section 2.5.

(4) **Termination of Eligibility of Surviving Dependents of Deceased Pension-Eligible Employees**. The eligibility of the surviving Dependents of a deceased Pension-Eligible Employee will terminate on the earliest of:

(A) For a surviving spouse, the date the surviving spouse remarries;

(B) For each individual Dependent other than a surviving spouse, on the date that Dependent no longer qualifies as a Dependent under Section 1.6;

(C) Failure to make timely payment of any amount required by Section 2.5; or

(D) In the case of a Dependent who became eligible under paragraph 2.2(c)

effective before February 1, 1999, on the date five (5) years after the date on which the Pension-Eligible Employee died if death occurred prior to attaining age 62, unless the employee:

(i) Attained age 55 prior to his death;

(ii) Earned twenty-five (25) Benefit Units under the Pension Plan;

(iii) Earned two (2) Years of Eligibility in five (5) consecutive years immediately prior to his death; and

(iv) Earned ten (10) Years of Eligibility within fifteen (15) consecutive years immediately prior to his death.

(5) **Termination of Eligibility of a Dependent of a Retired Employee**. The eligibility of a Dependent of a Retired Employee will terminate under any one of the following circumstances:

(A) For a surviving spouse of a deceased Retiree, on the date the surviving spouse remarries; or

(B) On the date the Retired Employee's eligibility terminates other than by his death;

(C) For each individual Dependent other than a surviving spouse, on the date the person no longer qualifies as a Dependent as defined in Section 1.6; or

(D) Failure to make timely payment of any amount required by Section 2.5.

(6) **Termination of Eligibility of Surviving Dependents of Deceased COBRA-Qualified Employees**. The eligibility of the surviving Dependents of a deceased COBRA-Qualified Employee will terminate under any one of the following circumstances:

(A) For a surviving spouse, the date the surviving spouse remarries;

(B) For each individual Dependent other than a surviving spouse, on the date that Dependent no longer qualifies as a Dependent under Section 1.6;

(C) Failure to make timely payment of any amount required by Section 2.5; or

(D) On the date twelve (12) months after the date on which the COBRA-Qualified Employee dies and his Hour Bank is reduced to less than 125 hours.

(f) Continuation of Coverage by Self-Payment

An Active Employee whose coverage would otherwise terminate under paragraph 2.1(c) may continue his eligibility for himself and his Dependents by making contributions on his behalf to the Fund. (See Section 2.4 for alternative continuation coverage.) The amount of the contribution is determined and may be changed at any time by the Board of Trustees. The following limitations apply:

(1) Unless employment is precluded by a medical disability and proof of application for a Social Security Disability Retirement Benefit is submitted, the Active Employee must be available for and willing to accept work as reflected in the hiring hall records of the Union.

(2) Payments must be received by the 20th of the month prior to the month for which coverage is desired.

(3) Payments must be continuous for as long as the Employee is ineligible.

(4) Payments may not be made for more than twelve consecutive calendar months unless the Active Employee submits proof of application for a Social Security Disability Retirement Benefit, is not currently employed due to a medical disability, and makes application for self-payment within six calendar months of the onset of the disability. The opportunity to make self-payment will terminate if a denial of a Social Security Disability Retirement Benefit is affirmed by an Administrative Law Judge or the Active Employee returns to work..

(g) Benefits

Coverage for Active Employees and their Dependents is as follows:

SCHEDULE OF BENEFITS PROVIDED

The Trust will provide the following categories of benefits for the classifications indicated, as more specifically described in the most recent agreements between the Fund and its insurers and health care providers. All benefits are subject to modification or termination as provided in paragraph 2.6(a) of the Revised Eligibility Rules.

1. Active Employees Under the Residential Agreement

For Active Employees under the Residential Agreement, coverage includes hospital-medical, life insurance, dental, and accidental death and dismemberment. For dependents of Active Employees under the Residential Agreement, coverage includes hospital-medical and dental benefits.

2. Active Employees Under the Inside Construction Agreement

For Active Employees under the Inside Construction Agreement, coverage includes hospital-medical, life insurance, dental, and accidental death and dismemberment. For dependents of Active Employees under the Inside Construction Agreement, coverage includes hospital-medical and dental benefits.

3. Retired Employees

For eligible Retired Employees and their Dependents who do not elect reimbursement pursuant to paragraph 2.2(e) of the Revised Eligibility Rules, coverage includes hospital-medical and dental benefits. Benefits are not provided for service under the Residential Agreement for Retired Employees or their Dependents.

Benefits are subject to termination under paragraph 2.6(a). Benefits for dependents shall be subject to any order issued by a court or state administrative agency relating to medical child support and qualifying as a Qualified Medical Child Support Order (QMCSO). No such order, assignment or claim may require the Plan to provide benefits to someone not eligible under the rules of the Plan or to provide benefits in excess of the amounts stated in the applicable description of benefits. In determining whether an order qualifies as a QMCSO, the Trustees will observe the procedures described in Appendix D, "Qualified Medical Child Support Orders."

(h) Dependent's Primary Coverage

Notwithstanding any other provision of this Plan, Dependents entitled to participate as a benefit of employment in another plan of medical or dental benefits shall be required to use that plan as their primary plan of benefits and they shall not be entitled to benefits under this Plan to the extent that coverage is available to them under the other plan.

(i) Termination for Cause

(1) The Fund is not responsible for maintaining the relationship between the Participant and the current health care provider(s). Agreements between the Fund and the current health care provider(s) permit termination of coverage for cause, including but not limited to the failure of the Participant or any Dependent to establish or maintain a satisfactory physician-patient relationship, the providing of incorrect or incomplete information, or the misuse of any identification card. Termination for cause may prevent the Participant or Dependent or both from obtaining coverage under any other contract for health care services to which the Fund is a party. If a Participant is unable to obtain coverage under any of the services agreements maintained by the Fund, the Participant will be permitted to apply for reimbursement of premiums paid for medical and/or dental coverage in an amount determined by the Board of Trustees. Reimbursement will not be available if only a Dependent is terminated.

(2) The amount reimbursed may include a deduction in a reasonable amount for administrative costs. Reimbursement shall be made only on a quarterly basis, even if the premium paid by the Participant is for a shorter term. The Fund shall require proof of payment and coverage as a condition for reimbursement.

(j) Family and Medical Leave Act

The Family and Medical Leave Act (FMLA), effective August 5, 1993, requires an employer to maintain coverage under any group health plan for an employee on FMLA leave under the same conditions for which coverage would have been provided if the employee had continued working. Compliance with the requirements of the Family and Medical Leave Act to maintain coverage by submitting required contributions during a period of family or medical leave is the sole responsibility of the employer and is not an obligation of the Trust.

Section 2.2 Eligibility Rules for Retired Employees

(a) Coverage

This Section 2.2 applies only to work performed under the Inside Construction Agreement between the Solano and Napa Counties Branch, Northern California Chapter, NECA, and Local Union 180 of the International Brotherhood of Electrical Workers ("Inside Construction Agreement").

(b) Initial Eligibility

(1) A person retiring prior to July 23, 1981 and not engaging in employment of any kind for wages or profit in the electrical industry in the United States on or after July 23, 1981 is eligible as a Retired Employee if he worked for a Contributing Employer under the Solano-Napa Counties Health and Welfare Plan for 10 years or since the beginning of his work experience in the electrical industry in Solano and Napa Counties, and if he:

(A) Has attained age 62 and is no longer working in the industry, or

(B) He is currently receiving a Social Security Disability Retirement Benefit based upon a total and permanent disability.

(2) A person retiring after July 22, 1981 and prior to August 1, 1986 and not engaged in employment of any kind for wages or profit in the electrical industry in the United States on or after August 1, 1986 is eligible as a Retired Employee if he:

(A) Has attained 62, or is currently receiving a Social Security Disability Retirement Benefit based upon a total and permanent disability, and

(B) Is receiving a pension under the Pension Plan.

(3) After July 31, 1986, a person is eligible as a Retired Employee if he:

(A) Has attained age 62, or is currently receiving a Social Security Disability Retirement Benefit based upon a total and permanent disability, and

(B) Is receiving a pension under the Pension Plan on the basis of not less than ten (10) years of credited service without a permanent break in service, and

(C) Earned two Years of Eligibility in five (5) consecutive Years immediately prior to his effective date of eligibility under paragraph 2.2 (b), and

(D) Earned ten (10) Years of Eligibility within fifteen (15) consecutive Years immediately prior to his effective date of eligibility under paragraph 2.2(c).

(4) After January 1, 1993, a person is eligible as a Retired Employee if he:

(A) Has attained age 55, or is currently receiving a Social Security Disability Retirement Benefit based upon a total and permanent disability, and

(B) Is receiving a pension under the Pension Plan on the basis of not less than ten (10) years of vested service without a permanent break in service, and

(C) Met the eligibility requirements in paragraphs 2.1(a) and (b) for twenty-four (24) calendar months of the sixty (60) consecutive calendar months immediately prior to his effective date of eligibility under paragraph 2.2(c), and

(D) Met the eligibility requirements in paragraphs 2.1(a) and (b) for one-hundred twenty (120) calendar months of the one hundred eighty (180) consecutive calendar months immediately prior to his effective date of eligibility under paragraph 2.2(c).

(5) The charge for coverage for each of the enumerated groups shall be set by the Board of Trustees, in its sole discretion, from time to time.

(c) Effective Date of Eligibility for Retiree and Dependent-Continuation Benefits

(1) Retired Employee's eligibility becomes effective on the latest of the following dates:

(A) On the first day of the month for which a pension is first payable to him under the Pension Plan; or with respect to a Retired Employee described in paragraph 2.2(b)(1) above, on the first day of the month following the date on which he submits a copy of his Social Security Disability Retirement Benefit award letter to the Fund;

(B) On the date on which his eligibility as an Active Employee terminates; or

(C) On the first day of the month following the month in which his application for benefits is submitted to the Fund.

(2) A Retired Employee's Dependent becomes eligible on the effective date of the Retired Employee's eligibility. Effective February 1, 1999, a Dependent of a deceased Pension-Eligible Employee is granted six months of free coverage after the hour bank of the Pension-Eligible Employee is reduced to below 125 hours. Thereafter the dependent must make the required contribution to continue coverage as required under paragraph 2.5(a)(5).

(d) Applications for Retiree and Dependent-Continuation Benefits

(1) An application for Retiree coverage shall be made by a Retired Employee on or before the date ninety (90) days following the date on which the Retired Employee satisfies the requirements of paragraph 2.2(b) for eligibility. Retired Employees shall be required to pay the monthly amounts described in Section 2.5 to maintain coverage for themselves and their Dependents.

(2) An applicant for coverage as a disability Retiree is not considered to be "currently receiving a Social Security Disability Retirement Benefit based upon a total and permanent disability" until the first day of the calendar month following receipt by the Fund of notice that the Social Security Disability Retirement Benefit has been approved**.**

(3) An application to continue Dependent coverage will be necessary for the Dependents of a deceased Retiree, Dependents of a deceased Pension-Eligible Employee, or Dependents of a deceased COBRA-Qualified Employee.

(A) The application by the Dependents of a Retiree may be made at any time within ninety (90) days following the death of the Retiree. The electing Dependents shall be required to pay the monthly amounts described in Section 2.5 to maintain coverage. Contributions required and due but unpaid since the death of the Retiree must be tendered to the Plan along with the application form within the ninety (90) day application period or the application will not be accepted.

(B) The application by Dependents of a deceased Pension-Eligible Employee or deceased COBRA-Qualified Employee may be made at any time within ninety (90) days following the death of the Pension-Eligible Employee.

(C) An application on behalf of a minor Child can be made by the Child's parent or legal guardian.

(e) Benefits Provided for Retired Employees and their Dependents

(1) Coverage for eligible Retired Employees and their Dependents is limited to 1) the benefits described in Appendix A, 2) the benefits described in Appendix E entitled "Rules and Regulations Providing Dental Benefits for Eligible Active and Retired Employees and 3) the most recent agreements between the Fund and insurer(s) or health care services provider(s) designated by the Trustee and is subject to termination under paragraph 2.6(a). In addition, Retirees living outside the service areas of health maintenance organizations providing coverage by those Agreements may apply for reimbursement, in an amount determined by the Board of Trustees, of premiums paid for medical and/or dental coverage. Reimbursement shall be made only on a quarterly basis, even if the premium paid by the Retired Employee is for a shorter term. The Trust shall require proof of payment and coverage as a condition for reimbursement. The amount reimbursed will not exceed the lesser of (i) the actual premium paid by the Retiree, or (ii) the composite rate charged to the Plan for Retiree coverage by the Kaiser Foundation Health Plan less any payment required of Retirees under Section 2.5.

(2) The elections made under this Section 2.2 shall be for full coverage or none. Except as may be provided in Section 2.4 with respect to COBRA continuation benefits, participating Retirees and Dependents, Dependents of deceased Pension-Eligible Employees and Dependents of deceased COBRA-Qualified Employees may not elect portions of benefit packages. For example, unless COBRA rules apply, the Plan will not offer hospital-medical coverage without dental benefits as long as dental benefits are continued for other Retirees.

(3) Retired Employees and their Dependents, Dependents of deceased Pension-Eligible Employees and Dependents of deceased COBRA-Qualified Employees shall be required to obtain and maintain Medicare Part A and Part B coverage from the date of eligibility for such coverage as a condition to receiving benefits under this Plan. The effective date of eligibility under this section may be delayed until evidence of coverage is submitted to the Fund where applicable.

(f) Other Grounds for Termination of Eligibility

(1) Benefits for Retired Employees and Dependents are subject to termination for cause as provided in paragraph 2.1(i).

(2) A Retired Employee's eligibility will terminate when his right to a pension from the Pension Trust Fund is terminated or suspended, or with respect to a Retired Employee described in Subparagraph 2.2(b)(1) above, when he engages in employment of any kind for wages or profit in the electrical industry in the United States.

(3) The eligibility of a Dependent of a Retired Employee will terminate under any one of the following circumstances:

(A) On the date the surviving spouse of a deceased Retiree remarries; or

(B) On the date the Retired Employee's eligibility terminates other than by his death; or

(C) On the date the person no longer qualifies as a Dependent as defined in Section 1.6.

Section 2.3 [Reserved]

Section 2.4 Eligibility for COBRA Continuation Benefits

(a) COBRA Continuation Coverage

Federal law requires the Solano-Napa Counties Electrical Workers Health and Welfare Plan to offer employees and their dependents (Qualified Beneficiaries) with an election pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") to pay for continued participation in certain of the Plan's medically-related benefits upon the occurrence of a Qualifying Event (described in paragraph 2.4(d)). The period of continued participation may be 18, 29 or 36, months depending on the Qualifying Event. The participant must pay the total premium and administrative costs for COBRA Continuation Coverage.

(b) Benefits Covered

A Qualified Beneficiary may elect to continue only (1) hospital-medical benefits which includes prescription drugs (core) or (2) hospital-medical benefits plus vision (when covered) and dental benefits (core and non-core). The level of coverage for those benefits will be the same as that provided to the Qualified Beneficiary on the day prior to the Qualifying Event. If coverage under the Plan is modified for Employees or Beneficiaries for whom no Qualifying Event has occurred, the same modification (including improvements or reductions) will be made in continuation coverage.

(c) Qualified Beneficiaries

A Qualified Beneficiary is any person who is receiving benefits under the Plan as an Active Employee or Dependent on the day before a Qualifying Event occurs. Effective January 1, 1997, a Qualified Beneficiary also includes any Dependent born to or adopted by an Employee while a period of COBRA Continuation Coverage is in effect, regardless of whether the Qualifying Event occurs before, on or after January 1, 1997. An individual is not a Qualified Beneficiary if, on the day before the Qualifying Event occurs, the individual is entitled to Medicare benefits under Title XVIII of the Social Security Act or health coverage through another group health plan.

(d) Qualifying Event

A Qualifying Event occurs, with respect to an Active Employee, any time that eligibility is terminated because the Active Employee has fewer than 125 hours in his Hour Bank on the last day of any calendar month.

A Qualifying Event with respect to a Dependent means any of the following events which results or may result in a termination of eligibility:

(1) The Active Employee has fewer than 125 hours in his Hour Bank on the last day of any calendar month;

(2) The death of the Active or Retired Employee;

(3) Divorce or legal separation of the Active or Retired Employee from the Employee's spouse;

(4) The Active or Retired Employee becoming entitled to Medicare benefits under Title XVIII of the Social Security Act;

(5) A dependent child ceasing to be a Dependent under the terms of this Plan.

Self payment for participants who qualify under Section 2.1(f) are in addition to and precede COBRA continuation coverage. Therefore, COBRA qualifying events and election periods are extended by the period of self-payments made pursuant to Section 2.1(f).

(e) How Long COBRA Continuation Coverage Lasts

(1) 18 months if coverage is lost due to a reduction in hours or termination of employment resulting in the employee's reserve hour bank falling below 125 hours;

(2) 36 months, for a Qualifying Event described in paragraph 2.4(d)(2) through (5);

(3) If a second Qualifying Event occurs during the 18 months following the date of a the Qualifying Event described in paragraph 2.4(d)(1), the date which is 36 months after the date of the Qualifying Event described in paragraph 2.4(d)(1).

(f) Extended COBRA Eligibility

(1) If eligibility is lost due to a Qualifying Event as described in paragraph 2.4(d)(1), the continuation coverage period may be extended beyond the original eighteen months from the date of the Qualifying Event to a total of 29 months for any Qualified Beneficiary who is determined by the Social Security Administration to be totally and permanently disabled at any time before or during the first sixty (60) days of COBRA Continuation Coverage. Qualified Beneficiaries in the disabled Qualified Beneficiary's family are also entitled to the 29-month extended coverage period. This extended COBRA eligibility shall only be available if, within the 18-month coverage period, the Qualified Beneficiary notifies the Fund Manager of the Social Security Administration's disability determination within sixty (60) days after it is made. Such notice shall also state the date that the individual will become entitled to Medicare. This extended COBRA eligibility will terminate before the full 29 months have elapsed upon the occurrence of any of the events (including the Qualified Beneficiary's becoming entitled to Medicare) that would otherwise cause an early termination of COBRA coverage. In addition, a person's eligibility for extended COBRA coverage under this rule will terminate as of the first day of the first month that begins more than thirty (30) days after the date of a final determination by the Social Security Administration that the individual is no longer disabled. If the Social Security Administration determines that a Qualified Beneficiary who is on extended COBRA coverage is no longer disabled, the individual shall notify the Fund Manager within thirty (30) days.

(2) Under the current provisions, this Plan does not terminate coverage of a spouse or dependent of an Employee or former Employee when the Employee becomes entitled to Medicare. If changes in the Plan occur such that an Employee's entitlement to Medicare becomes a Qualifying Event for a spouse or dependent of the Employee, then the following provision concerning the duration of COBRA coverage shall apply: If an Employee has a Qualifying Event under paragraph 2.4(d)(1) due to a termination or reduction of hours, and within less than 18 months becomes entitled to Medicare, causing the spouse or dependent of the Employee to lose coverage, the spouse or dependent is entitled to up to a maximum of 36 months of COBRA coverage from the date of the initial Qualifying Event of the Employee's termination or reduction of hours. If the Employee becomes entitled to Medicare and within less than 18 months has a second Qualifying Event under paragraph 2.4(d)(1) due to a termination or reduction of hours, the spouse or dependent of the Employee is entitled to up to a maximum of 36 months of COBRA coverage from the date of the Employee's entitlement to Medicare.

(3) For purposes of paragraph (2) above self-pay periods and COBRA periods will run concurrently and all periods of self-pay will be considered as satisfying COBRA coverage requirements.

(g) Continued Coverage of Pre-Existing Condition

A Qualified Beneficiary who becomes covered under another employer-sponsored health plan as described in paragraph 2.4(h)(3) will not cease to be eligible for COBRA coverage on that basis if the new plan contains any exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary. To be eligible for continued COBRA coverage under this rule, the Qualified Beneficiary must demonstrate to the satisfaction of the Fund Manager that:

(1) He or she has a condition requiring treatment by a licensed health care professional,

(2) That the health condition existed before the Beneficiary became eligible for coverage under the new plan, and

(3) The new plan has an exclusion or limitation with respect to that condition which applies to the Beneficiary. In accordance with the Health Insurance Portability and Accountability Act of 1996 (Internal Revenue Code Section 9801), a group health plan may impose a preexisting condition exclusion on or after June 30, 1997 (effective date applicable to most plans) only if:

(A) The pre-existing condition (whether physical or mental) is one for which the participant or beneficiary received medical advice, diagnosis, care or treatment within the 6-month ending on the date of the individual's enrollment in the new group health plan, or if earlier, on the first day of the waiting period for enrollment;

(B) The pre-existing condition exclusion does not extend for a period of more than 12 months (or 18 months in the case of a late enrollee) after the enrollment date; and

(C) The period of any such pre-existing condition exclusion is reduced by the length of any periods of ceditable coverage applicable to the participant or beneficiary as of the enrollmenbt date. Creditable coverage means coverage under the prior group health plan, COBRA continuation coverage or other coverage as defined in Internal Revenue Code Section 9801(c). A period of creditable coverage may not be counted if there is a break in coverage. A break in coverage occurs when there is no creditable cvoverage in effect for the individual during the sixty-three (63) days prior to the enrollment date in the new group health plan. A waiting or affiliation period under the new group health plan may not be treated as a break in coverage.

(D) Notwithstanding the foregoing, the new group health plan may not impose any preexisting condition exclusion with respect to certain newborns and adopted children as provided in Internal Revenue Code Section 9801(d), or with respect to pregnancy as a preexisting condition.

For coordination of benefits purposes, a former employee shall be treated like a laid-off or retired employee.

(h) Termination of Coverage

COBRA Continuation Coverage will terminate upon the occurrence of any of the following:

(1) Completion of the maximum period of coverage under paragraphs 2.4(e) or (f);

(2) Failure to make timely payment of any premium required under the Plan;

(3) The Qualified Beneficiary first becomes:

(A) Eligible for coverage under any other group health plan (as an employee or otherwise) which does not contain, or under the Health Insurance Portability and Accountability Act of 1996 (as described in paragraph 2.4(g)(3) of these Eligibility Rules), is prohibited from imposing, any exclusion or limitation with respect to any preexisting condition of such beneficiary; or

(B) Entitled to Medicare benefits under Title XVIII of the Social Security Act, unless the Qualified Beneficiary is eligible for Continued Coverage as provided in paragraph 2.4(g) regarding pre-existing conditions;

(4) The Trust no longer provides group health coverage. If the Trust terminates its agreement with any health services provider but maintains health care services agreements with other providers, the Trust will offer Qualified Beneficiaries who are covered under the discontinued plan of benefits an opportunity to elect to be covered under any of the remaining plans. If the discontinued plan was subject to deductibles (or limits in the nature of deductibles, such as copayment limits or catastrophic limits) and the change occurs before the end of the prescribed period for accumulating the deductibles, the new coverage selected by the Qualified Beneficiary will give credit for the amounts incurred under the original coverage.

(i) Premium Amount

The Plan shall require payment of a premium for any period of COBRA Continuation Coverage, which shall be fixed annually by the Trustees for a 12 month period and shall not exceed one hundred two percent (102%) of the cost to the Plan for the same period of the coverage for similarly-situated Employees or Dependents for whom a Qualifying Event has not occurred, including the administrative and operating costs of the Plan (at such time as the laws permit) as well as insurance or benefit costs. The charge for extended COBRA coverage under paragraph 2.4(f)(1) for total disability may be up to 150% of the applicable premium, applied to coverage for each month after the month in which COBRA eligibility would have expired in the absence of this rule.

(j) Time for Payment

The initial premium for a period of COBRA Continuation Coverage shall be due on the date of the election required by paragraph 2.4(l) and shall be accepted by the Plan if made within forty-five (45) days thereafter. The initial premium shall include the premium for any period of continuation coverage preceding the election. The payment of any other premium may be made in monthly installments and shall be due on the tenth (10th) day of the month prior to the month of coverage ("Premium Due Date"). Payments made later than thirty (30) days following the due date will be untimely and result in termination of COBRA Continuation Coverage. Coverage cannot be reinstated once terminated or waived, except as provided in paragraph 2.4(n).

(k) Notice of Intent to Discontinue Coverage

This Plan is required by contracts of health coverage to pay premiums to the health carriers prior to or at the commencement of the month in which coverage is to be provided. Any person receiving COBRA Continuation Coverage who intends to discontinue payment of premiums is required to notify the Fund Office in writing not later than the Premium Due Date for the month in which coverage will be discontinued. As a condition of the election for continuation coverage, the Plan shall have a right:

(1) To recover from the Qualified Beneficiary the premium for each period of coverage until proper notice is given, or alternatively to withhold payment of the premiums to the health carriers until payment from the Qualified Beneficiary is received; and

(2) To collect, or authorize any health service provider under the Plan to collect, a charge from the Qualified Beneficiary for services rendered by the health carrier at any time when the Qualified Beneficiary's failure to pay a premium results in a lapse of coverage.

In no circumstance shall the Plan have an obligation to pay a premium for coverage for any Qualified Beneficiary prior to the time that it receives payment from the Qualified Beneficiary or to reimburse the Qualified Beneficiary for any cost for medical services which may be incurred during a lapse of coverage resulting from the failure to make timely payment of premiums.

(l) Election Period

A Qualified Beneficiary shall be entitled to make an election for COBRA Continuation Coverage commencing on the date on which coverage terminates because of a Qualifying Event, or, if the Fund Manager receives timely notice under paragraph 2.4(p), the date on which the Fund Manager gives the Qualified Beneficiary the notice required by paragraph 2.4(q), whichever occurs later, and continuing for a period of sixty (60) days thereafter ("Election Period"). A Qualified Beneficiary who fails to elect COBRA Continuation Coverage ceases to be a Qualified Beneficiary at the end of the Election Period. If the election is made within the Election Period, coverage will be provided from the date that coverage would otherwise have been lost upon timely payment of the first premium. Timely payment requires payment within forty-five (45) days of the election.

(m) Persons Affected by the Election

An election to accept continuation coverage made by an Employee or an Employee's spouse will be binding upon any other Qualified Beneficiary who is entitled to COBRA Continuation Coverage with respect to the Employee's participation in this Plan. Otherwise, each Qualified Beneficiary shall be entitled to make an election independently of any other. An election on behalf of a minor child can be made by the child's parent or legal guardian. An election on behalf of a Qualified Beneficiary who is incapacitated or dies can be made by the legal representative of the Qualified Beneficiary or the Qualified Beneficiary's estate. At any time that there may be a choice for Employees among types of coverage under the Plan, each Qualified Beneficiary shall be entitled to make a separate selection among the types of coverage.

(n) Waiver of the Election

A Qualified Beneficiary who waives COBRA Continuation Coverage may revoke the waiver at any time during the Election Period. In such a case, the Trust will provide coverage only from the date of revocation of the waiver and not from the date of the loss of coverage.

(o) Notice Obligations of the Employer

Every Employer shall be obligated to notify the Fund Manager within thirty (30) days following the occurrence of the following Qualifying Events with respect to one of its employees:

(1) The death of the Employee;

(2) The Employee becoming eligible for Medicare benefits under Title XVIII of the Social Security Act;

(3) A termination or reduction of hours for which notice of such event is required under a Subscription Agreement.

(p) Notice Obligations of Employees and Qualified Beneficiaries

(1) Every Employee shall be obligated to notify the Fund Manager within sixty (60) days following the occurrence of one of the following Qualifying Events:

(A) The divorce or legal separation of the Active or Retired Employee from the Employee's spouse;

(B) A dependent child ceasing to be a Dependent under the terms of this Plan;

(C) A determination by the Social Security Administration that the Qualified Beneficiary is permanently and totally disabled as of the date of termination or reduction of hours that became a qualifying event. For the notice to qual-qualify to extend the continuation coverage period, it must be given within the 18-month period that would have applied for a Qualified Beneficiary who was not disabled.

(2) To be eligible for extended COBRA Coverage as provided in paragraph 2.4(f), a Qualified Beneficiary who is on COBRA coverage as of February 1, 1990 and who received a Social Security disability determination on or after October 18, 1989 must notify the Fund Manager of that Determination by the later of:

(A) Fourteen (14) days after the Fund sends out notice of the opportunity to take this extended coverage or

(B) Sixty (60) days after receiving the Social Security determination.

The Qualified Beneficiary must notify the Fund Manager within thirty (30) days of a determination by the Social Security Administration that the individual is no longer disabled.

(q) Notice Required of the Fund Manager

The Fund Manager shall notify any Qualified Beneficiary whose name appears on the records of the Plan of the occurrence of a Qualifying Event described in paragraph 2.4(d)(1), 2.4(d)(2) or 2.4(d)(4). The notice shall include a description of the rules relating to pre-existing conditions as described in paragraph 2.4(g). Any time that the Fund Manager receives the timely notice required of Employees and Qualified Beneficiaries under paragraph 2.4(p), it shall notify the Qualified Beneficiary whose name appears on the records of the Plan of that person's rights with respect to election of COBRA Continuation Coverage. In the latter case, the Fund Manager shall give such notice within fourteen (14) days after receiving notice under paragraph 2.4(p), and notice given to the spouse of an Employee shall be treated as notification to all other Qualified Beneficiaries residing with such spouse at the time notification is made.

(r) Conversion Options

If, at any time, the Plan offers Employees or Dependents an option to enroll in a conversion health plan, it shall offer the same option to Qualified Beneficiaries whose COBRA Continuation Coverage expires under paragraph 2.4(h)(1).

(s) Date of Election or Notice

Any notice, including notice of an election, will be treated as having been made, in the case of personal delivery, on the date when the written notice is actually delivered to person entitled to receive it, and in the case of notice sent by mail, on the date of mailing, as indicated by the postmark, if the notice is mailed with proper postage and properly addressed. Notice to a Qualified Beneficiary shall be properly addressed if sent to the last address for such person appearing on the Trust records.

(t) Certification of Creditable Coverage

The Fund Manager shall provide certification of creditable coverage received under this Plan in accordance with Internal Revenue Code Section 9801 and the regulations thereunder:

(1) At the time an individual ceases to be covered under the Plan or otherwise becomes covered under Section 2.4;

(2) In the case of an individual becoming covered under Section 2.4, at the time such individual ceases to be covered under Section 2.4; and

(3) On request on behalf of an individual made no later than 24 months after the date of cessation of the coverage in subparagraph (t)(1) or(t)(2), whichever is later.

Section 2.5 Retiree and Dependent Contribution and Medicare Coverage

Benefits for Retired Employees and their Dependents are subject to revision or termination at the discretion of the Board of Trustees. The following rate structure and subsequent modifications thereto do not imply vesting or permanency of benefits.

(a) Self-Pay for Retired Employees and Dependents Eligible Prior to February 1, 1999

Retired Employees and Dependents who first become eligible for coverage under paragraph 2.2(c) prior to February 1, 1999 shall be required to make self-payments to the Trust in order to maintain coverage for themselves and/or their Dependents, as follows:

(1) Retirees Between 55 and 62

Unless subparagraph 2.5(a)(2) applies, in order to be eligible for benefits under this Plan, Retired Employees between age 55 and 62 shall be required to make monthly payments to the Trust for themselves and their Dependents in an amount equal to the amount fixed by the Board of Trustees for Employees participating under a Subscription Agreement. This rate shall not be less than the amount of the premium charged to the Plan plus the allocated cost for self-funded dental coverage and Plan administration.

(2) Disability Retirees

Prior to age 62, Retired Employees currently receiving a Social Security Disability Retirement Benefit based upon a total and permanent disability shall be required to make monthly payments to the Trust in an amount equal to the amount fixed by the Board of Trustees for self-paid continuation coverage under paragraph 2.1(f). Between ages 62 and 65, Retired Employees currently receiving a Social Security Disability Retirement Benefit based upon a total and permanent disability shall be required to make the monthly payments specified in the following paragraph for Retirees between age 62 and 65.

(3) Retirees Between Age 62 and 65

Retirees between age 62 and age 65 shall be required to make monthly payments to the Trust in an amount fixed by the Board of Trustees. No payment will be required after the date on which the Retiree attains age 65.

(4) Dependents of Deceased Retiree

When a Retiree dies before age 65, Dependents desiring to continue coverage shall be required to make monthly payments in an amount equal to the amount fixed by the Board of Trustees for self-paid continuation coverage under paragraph 2.1(f) until the dates on which the deceased Retiree would have attained age 62 (or their eligibility terminates). If the deceased Retiree would have attained age 62 but not age 65, the monthly payment shall be in an amount fixed by the Board of Trustees. No payment will be required after the date on which the deceased Retiree would have attained age 65. Payment must commence with the first month following completion of a period of six (6) months

during which no contribution is required. The six (6) month period begins with the month following the month in which the Retiree dies.

(5) Dependents of Deceased Pension-Eligible Employee

When a Pension-Eligible Employee dies before age 65, Dependents desiring to continue coverage shall be required to make monthly payments in an amount equal to the amount fixed by the Board of Trustees for self-paid continuation coverage under paragraph 2.1(f) until the dates on which the deceased Pension-Eligible Employee would have attained age 62 (or their eligibility terminates). If the deceased Pension-Eligible Employee would have attained age 62 but not age 65, the monthly payment shall be in an amount fixed by the Board of Trustees. The time limits on coverage under paragraph 2.1(e)(4) will apply when the Employee dies prior to age 62. No payment will be required after the date on which the deceased Retiree would have attained age 65. Payment must commence with the first month following completion of a period of six (6) months during which no contribution is required. The six (6) month period begins with the month following the month in which the Hour Bank of the deceased Pension-Eligible Employee is reduced to less than 125 hours.

(b) Retired Employees and Dependents Eligible on or after February 1, 1999

In most instances, the cost of receiving retiree health coverage increased for Retired Employees and Dependents who first became eligible under paragraph 2.2(c) on or after February 1, 1999. Those persons shall be required to make payments to the Trust in order to maintain coverage for themselves and/or their Dependents, as follows:

(1) Retirees Between Ages 55 and 62

Unless subparagraph 2.5(b)(2) applies, Retired Employees between age 55 and 62 and their Dependents shall be required to make monthly payments to the Trust for each person in an amount fixed by the Board of Trustees, commencing in accordance with paragraph (c) below. This rate shall not be less than the amount of the expense to or premium charged to the Plan, plus the allocated cost for self-funded dental coverage.

(2) Disability Retirees and Retirees Age 62 and Over

Retired Employees age 62 and over, and Retired Employees currently receiving a Social Security Disability Retirement Benefit based upon a total and permanent disability, and their Dependents (other than Later-Acquired Dependents, who are covered by paragraph (b)(4), below) shall be required to make monthly payments to the Trust for each person in an amount fixed by the Board of Trustees, commencing in accordance with paragraph (c) below.

(3) Surviving Dependent

(A) Surviving Dependents of deceased Retired Employees, Disability Retirees and Pension-Eligible Employees shall be required to make monthly payments in accordance with paragraph (b)(2) above, regardless of age. Payment of contributions shall commence in accordance with paragraph (c) below.

(B) Commencing February 1, 2000, when a COBRA-Qualified Employee dies, Dependents desiring to continue coverage shall be required to make monthly payments in an amount equal to the amount fixed by the Board of Trustees for self-paid continuation coverage under paragraph 2.1(f). Payment of contributions shall commence in accordance with paragraph (c) below.

(4) Later-Acquired Dependents

Notwithstanding the foregoing, the self-payment rate applicable to all Later-Acquired Dependents shall be the rate under paragraph (b)(1) above, regardless of the Retired Employee's age or disability status. Payment of contributions shall commence in accordance with paragraph (c) below.

(c) Commencement of Contributions

(1) Initial Payment

To the extent that contributions are required under this section to maintain Retiree or Dependent coverage, the initial payment shall be due on the date of the application required by paragraph 2.2(d)(1) and shall be accepted by the Plan if made within forty-five (45) days thereafter. Notwithstanding the foregoing, contributions to maintain dependent coverage following the death of a Retiree or Pension-Eligible Employee shall not be required for a period of six (6) months following the death of a Retired Employee or, in the case of a deceased Pension-Eligible Employee, six (6) months following the date that the Employee's hour bank is reduced to less than 125 hours. Commencing February 1, 2000, and notwithstanding the foregoing, contributions to maintain dependent coverage following the death of a COBRA-Qualified Employee shall not be required for a period of six (6) months following the date that the Employee's hour bank is reduced to less than 125 hours. The initial payment for coverage of surviving Dependents shall be due within forty-five (45) days of the date of application required in 2.2(c)(3).

(2) Subsequent Payments

The payment of any other contribution following the initial payment shall be made in monthly installments and shall be due on the twentieth (20th) day of the month prior to the month of coverage. Payments made later than five (5) days following the first day of the month for which coverage is to be provided will be untimely and result in termination of coverage.

(3) Concurrent Coverage

The period of self-pay coverage under paragraph 2.5(b)(3), including, where applicable, any period of six (6) months under paragraph 2.5(c)(1) during which no contribution is required for continuation coverage, shall run concurrently, and not consecutively, with the maximum length of COBRA continuation coverage under paragraphs 2.4(e) and (f). During any period of concurrent coverage, a Dependent paying for continuation coverage will be required to pay only the lesser of the self-pay rate under paragraph 2.1(f) and the rate for COBRA coverage under Section 2.4. Continuation coverage under paragraph 2.5(b)(3) shall not extend the maximum length of COBRA continuation coverage under paragraphs 2.4(e) and (f), and termination of continuation coverage under paragraph 2.5(b)(3) is not a Qualifying Event under paragraph 2.4(d).

(d) Termination on Cessation of Payments

Once commenced, payment under this Section must be continuous and uninterrupted. Cessation of payments will terminate coverage. Coverage cannot be reinstated once terminated until the Retired Employee attains, or — in the case of the Dependent of the Retiree who dies before age 65 — the Retired Employee would have attained, age 65. If coverage is terminated because contributions cease, the limited reinstatement allowed by the previous sentence will be permitted only to the extent allowed by the service agreements with the Plan's health service providers, which may limit coverage and include pre-existing condition restrictions.

(e) Effect of Late Payment

Since this Plan is required by contracts of health coverage to pay premiums to the health carriers prior to or at the commencement of the month in which coverage is to be provided, the delay of payment beyond the date when it is due may result in an interruption or loss of coverage. Until written notice is received by the Fund Office from the Retired Employee or covered Dependent that coverage will be discontinued, the Fund Office may, in its sole discretion:

(1) Advance the premium and bill the delinquent Retiree or Dependent in the same manner as provided in Section 2.4 for late payments for COBRA coverage;

(2) Withhold payment of the premiums to the health carriers until payment from the Qualified Beneficiary is received; or

(3) Collect, or authorize any health service provider under the Plan to collect, a charge from the Retiree or Dependent for services rendered by the health carrier at any time when the failure to pay a premium results in a lapse of coverage.

In no circumstance shall the Plan have an obligation to pay a premium for coverage for any Retiree or Dependent prior to the time that it receives payment or to reimburse the Retiree or Dependent for any cost for medical services which may be incurred during a lapse of coverage resulting from the failure to make timely payment of premiums.

(f) Authority to Increase Contributions

The amount of contribution determined by the Board of Trustees may be changed at any time.

(g) Assignment of Medicare Coverage

Any Retired Employees or Dependents required to apply for and maintain benefits under Part A and Part B of Medicare under paragraph 2.2(e)(3) may be required to assign Part B coverage to the Fund or, pursuant to a contract for coverage negotiated under paragraph 2.2(e)(1), to a carrier providing coverage to the Retired Employee.

(h) Excess Cost Reimbursement

When the premium paid by the Fund for any Retired Employee or his Dependents exceeds the premium paid by the Fund for an Active Employee or an Active Employee and his Dependents, the Retired Employee (or eligible Dependent of a deceased Employee) may be required as a condition of continued participation to make payments to the Fund in the amount of the excess cost. When the Fund contracts with more than one insurance carrier or health care services provider, the excess cost may be measured by the least expensive insurance or health care contract in effect for the same level of coverage, or any other contract in effect that the Trustees may select on a non-discriminatory basis.

Section 2.6 Miscellaneous

(a) Termination of Benefits

(1) Nothing in these rules, the Trust Agreement, or any act of the Fund shall be interpreted as providing a vested benefit or promise of future or continued benefits, whether for Active Employees, Retired Employees or their Dependents, whether before or after commencement of coverage.

(2) The Trustees may in their sole discretion modify or terminate benefits under this Plan, or add or delete insurance carriers or benefit providers, at any time and for any class of participants whether before or after commencement of coverage under the Plan.

(b) Information and Proof

Every Active Employee, Retired Employee or covered Dependent shall furnish, at the request of the Fund, any information or proof reasonably required to determine his benefit rights. If the claimant willfully makes a false statement material to an application or furnishes fraudulent information or proof material to his claim, or fails to provide the notifications required, benefits under this Plan may be denied, suspended or terminated. The Fund shall have the right to recover any benefit payments or be reimbursed for any premium payments made prior to the receipt of any required notifications, or in reliance upon:

(1) Any material false or fraudulent statement, information or proofs submitted to the Fund;

(2) An application for coverage subsequently determined to have been made without legal authority or by a person not competent to make it;

(3) The failure of an Active Employee, Retired Employee, or Dependent to notify the Fund within ten (10) days after loss of eligibility or change in Dependent status; or

(4) A court order subsequently reversed or invalidated.

(c) Annual Certification

(1) At least once each year the Fund shall require each Retired Employee and Dependent to certify as to his continuing eligibility for benefits. Persons retired due to disability shall be required to

submit evidence of continuing Social Security Disability Retirement Benefit payments. Retired Employees and their Dependents eligible for Medicare shall be required to submit evidence of continuing coverage.

(2) A Retired Employee who retires prior to August 1, 1986, shall be required, as a condition to receiving future benefits, to certify annually and more frequently where appropriate that he is unemployed and was unemployed during the prior year. If the Retired Employee becomes employed, he may be required to provide factual information to the Fund sufficient to establish that the employment does not result in any loss of eligibility.

(d) Notice of Termination of Eligibility

Upon an event resulting in termination of eligibility for a Retired Employee or Dependent, or for a person making self-payments under paragraph 2.1(f)(4) pending application for a Social Security Disability Retirement Benefit award, the Employee, or Dependent when the Employee is deceased, shall be required to notify the Fund in writing within ten (10) calendar days, stating the reason for termination of eligibility or Dependent status.

(e) Action of Trustees

The Trustees shall, subject to all requirements of law, have sole discretion interpreting this plan, determining eligibility for benefits and shall be the sole judges of the standard of proof required. Decisions of the Trustees shall be final and binding on all parties.

(f) No Right to Assets

No person other than the Trustees of the Fund shall have any right, title or interest in any of the income, property, or funds received or held by or for the account of the Fund.

(g) Coordination of Benefits

The Fund may provide for coordination of benefits in any contract negotiated under the Plan with an insurer or health care services provider. Benefits payable under more than one group program shall be integrated to avoid payment of more than 100% of allowable expenses. If any such contract does not provide for coordination of benefits, the following shall apply:

(1) If a person is entitled to coverage under two or more group insurance policies or group prepaid health care programs, the policy or program covering the patient as an employee shall be primary over the policy or program covering the patient as a dependent, and the policy of the program covering the patient as a dependent child of the parent whose birthday falls earlier in the calendar year shall be primary over the policy or program covering the patient as a dependent of the parent whose birthday falls later in the calendar year; provided, if both parents have the same birthday, the policy or program which has covered the eligible patient for the longer period of time shall be primary; provided further, that in the case of a dependent child of legally separated or divorced parents, if the mother has legal custody, then the policy or the program covering the patient as a dependent of the mother, or as a dependent of her spouse if she has remarried, shall be primary over the policy or program covering the patient as a dependent of the natural father.

(2) If the other Plan does not contain provisions adopting the "birthday rule" of the previous paragraph, the coordination rule of the other plan shall apply.

(3) If the program provided by this Plan is "primary", as provided above, this Plan shall provide benefits without any regard to another policy or program, and if the program provided by this Plan is not "primary", this Plan shall provide benefits only to the extent that services which are benefits provided by this Plan are not fully paid for or provided for under the terms of such other policy or program.

(h) Subrogation of Claims and Restitution of Overpayment

The Fund may provide in any contract with an insurer or health care services provider for subrogation of claims or restitution of overpayment in the event that benefits are paid or payable on account of an injury caused or alleged to be caused by an act or omission of a third party. In the event that any such contract does not provide for subrogation of claims, the following shall apply with respect to benefits paid directly by the Fund or under an experience-rated contract:

(1) Where injury or illness is caused or alleged to be caused by any act or omission of a third party, expenses are not covered under the plan to the extent that payment or reimbursement has been or may be received by the Employee or Dependent, his or her estate, parent or legal guardian, from the third party or its insurer on account of the injury or illness.

(2) If benefits have been paid or services rendered under the Plan for an Employee or Dependent for which that person or his legal representative is reimbursed or obtains recovery by settlement or judgment from a responsible third party or its insurer, the Fund (or its carrier) shall be entitled to restitution or refund of the amount of the benefits paid. The restitution or refund shall not exceed the total amount of any reimbursement or recovery from or on behalf of the third party. The right to restitution or refund shall not depend upon the purpose for which any settlement fund may be specified and shall exist whether or not medical costs are stated as a separate item or damages in any judgment. The Trustees shall have the right to use legal or equitable remedies, in State or Federal Court, to collect overpaid claims. In the event equitable remedies are sought the trustees may impose a constructive trust upon any proceeds subject to restitution regardless of whoever has possession of said funds. This equitable lien shall take priority over and attorney fees or costs claimed against the recovery or settlement.

(3) If payment or reimbursement has not been paid for such expenses at the time the claim is submitted under the Plan, such expenses shall not be excluded for the purposes of the claim if they otherwise qualify as covered expenses under the Plan. But upon payment of any portion of a claim, the Fund (or its carrier) shall be subrogated to all of the Employee's or Dependent's rights of action and recovery against any person or persons for such expenses (other than under an individual policy of insurance issued to the Employee or Dependent and containing express provisions for payment of benefits for medical expenses). The Fund may elect not to exercise its right of subrogation, but such action shall not waive or otherwise prejudice its right to a refund according to the preceding subparagraph.

(4) The Employee or Dependent will be required before payment of benefits under the Plan to execute any assignments and provide any information, documents or releases of medical records necessary for the purpose of enforcing the Fund's (or carrier's) right of subrogation, and to execute an agreement directing his or her attorney to make payments directly to the Fund or carrier.

APPENDIX A

SCHEDULE OF BENEFITS PROVIDED

The Trust will provide the following categories of benefits for the classifications indicated, as more specifically described in the most recent agreements between the Fund and its insurers and health care providers. All benefits are subject to modification or termination as provided in paragraph 2.6(a) of the Revised Eligibility Rules.

1. Active Employees Under the Residential Agreement

For Active Employees under the Residential Agreement, coverage includes hospital-medical, life insurance, dental, and accidental death and dismemberment. For dependents of Active Employees under the Residential Agreement, coverage includes hospital-medical and dental benefits.

2. Active Employees Under the Inside Construction Agreement

For Active Employees under the Inside Construction Agreement, coverage includes hospital-medical, life insurance, dental, and accidental death and dismemberment. For dependents of Active Employees under the Inside Construction Agreement, coverage includes hospital-medical and dental benefits.

3. Retired Employees

For eligible Retired Employees and their Dependents who do not elect reimbursement pursuant to paragraph 2.2(e) of the Revised Eligibility Rules, coverage includes hospital-medical and dental benefits. Benefits are not provided for service under the Residential Agreement for Retired Employees or their Dependents.