SOLANO-NAPA COUNTIES ELECTRICAL WORKERS HEALTH AND WELFARE PLAN

Restated Summary Plan Description
and
Plan Document

**(For Inside Wire Members and Residential Agreement members of IBEW LOCAL 180.
Including Retirees, Spouses, and Dependents)**

Benefits in effect as of JANUARY 2019

Keep this Summary Plan Description and Plan Document For Future Reference

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Dear Plan Member, Spouse and Dependent:

We are pleased to provide you with this **restated new booklet** known as a Summary Plan Description ("SPD") which is both the Summary and the actual Plan document for the Solano-Napa Counties Electrical Workers Health and Welfare ("Plan"). This booklet contains an explanation of the eligibility provisions and benefits for both active and retired Participants and their dependents (as defined by the Plan). Additional information on the Plan, including a variety of forms, can be obtained from the Trust Fund's website, which is *www.ourbenefitoffice.com/IBEW180/Benefits*. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Plan Office at (925) 208-9980.

Eligible active participants are offered medical, mental health/substance abuse disorder, prescription drug benefits provided by contract with the Kaiser Foundation Health Plan. Eligible retired participants are offered medical, mental health/substance abuse disorder, and prescription benefits provided by contract with Kaiser or UHC. The Plan also provides dental care, vision care, life insurance, and accidental death and dismemberment benefits for active participants, retirees, and their eligible dependents. Except for life insurance and accidental death and dismemberment benefits, Plan benefits are payable for non-occupational illnesses and injuries.

The Board of Trustees has the discretionary authority to decide all questions about the Plan, including questions about your eligibility for benefits, the amount of any benefits payable to you, and the interpretation of the Plan. No Individual Trustee, Employer, or Union Representative has authority to interpret this Plan on behalf of the Board of Trustees or to act as an agent of the Board of Trustees. The Board of Trustees 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.

The Board of Trustees has authorized the Plan Office to respond in writing to your written questions. As a courtesy to you, the Plan Office may respond informally to oral questions; however, oral information and answers are not binding upon the Board of Trustees or the Plan and cannot be relied on in any dispute concerning your benefits. If you have an important question about your benefits, you should write to the Plan Office at:

Solano-Napa Counties Electrical Workers Health and Welfare Trust Fund
2610 Crow Canyon Road, Suite 200
San Ramon, CA 94583
Phone: (925) 208-9980

Plan rules and benefits may change from time to time. Your benefits under the Plan are NOT vested. The Board of Trustees may reduce, eliminate or change any benefit provided under the Plan or any insurance policy, HMO or other entity at any time. The Plan will provide you with a summary of important material changes. You may also receive replacement pages for this booklet. Please be sure to read all Plan communications and keep your booklet up to date by adding replacement pages as soon as you receive them.

Sincerely,
The Board of Trustees

SOLANO-NAPA COUNTIES ELECTRICAL WORKERS HEALTH AND WELFARE TRUST FUND

2610 Crow Canyon Road, Suite 200
San Ramon, CA 94583
(925) 208-9980

BOARD OF TRUSTEES

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ADVISORS TO THE PLAN

FUND MANAGERS

Richard McClaskey, Plan Manager
Rebecca Clark, Plan Associate
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Pleasanton, CA

LEGAL COUNSEL

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AUDITOR

Jasmine Baker
Lindquist, LLP

San Ramon, CA

BENEFIT CONSULTANT

Gohn Marie McFadden
McFadden & Associates Insurance Services LLC
Oakland, CA

IMPORTANT REMINDERS

It is your responsibility to notify the Trust 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 provided within thirty (30) days of the marriage, birth or adoption.

(2) If you divorce or legally separate from your spouse or terminate your domestic partnership with your domestic partner.

(3) If a Dependent child ceases to be a dependent under the terms of this Plan. For example, your dependent child ages out of the Plan (turns age 26).

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

(5) If you are eligible for and fail to enroll in Medicare Parts A and B, the Plan will not pay your claims. **To be eligible for Retiree Health and Welfare benefits under this Plan you and/or your eligible Dependent are required to enroll in both Medicare Parts A and B and pay the required premium (for part B) as soon as you and/or your eligible Dependent(s) are entitled to coverage.**

(6) If you change your address or contact information.

Employees, retirees and their eligible dependents must notify the Trust Fund Office within thirty (30) days following any of the events described in paragraphs (1) through (5).

If you fail to notify the Trust Fund Office within thirty (30) days following the addition of a new dependent, should you subsequently enroll your dependent your dependent's coverage will not become effective until the first of the month after you have applied and provided any necessary documentation to establish their eligibility as a dependent. In the event you or your spouse are covered only by another group health 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.

FUTURE PLAN AMENDMENTS

Future amendments to the Plan may be made to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Trustees. You will be notified if there are important amendments to the Plan through written notification. Before you decide to retire, you may want to contact the Plan Office to determine if there have been Plan amendments or other developments that may affect your retirement plan options.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS

This booklet provides a brief, general summary of the Plan rules and is also the Plan document. You should review the Plan to fully determine your rights. **You are not entitled to rely upon oral statements of Employees of the Plan Office, a Trustee, an Employer, any Union representative, or any other person or entity.**

As a courtesy to you, the Plan Office may respond orally to questions; however, oral information and answers are not binding upon the Plan and cannot be relied upon in any dispute concerning your benefits. If you would like an interpretation of the Plan, you should address your request in writing to the Board of Trustees at the Plan Office. To make their decision, the Trustees must be provided with full and accurate information concerning your situation. You should also ensure that you provide accurate facts in all forms and documents submitted to ensure you are not held liable for coverage of ineligible Dependents and/or claims.

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

NO GUARANTEE OF PROVIDER

The continued participation of any one physician, hospital, or other provider cannot be guaranteed. The fact that a physician or provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it medically necessary or guarantee that it is a covered service.

NO VESTED RIGHTS

Benefits under this Plan are NOT vested. The Board of Trustees may in their sole discretion amend, reduce, eliminate or otherwise change the Plan at any time and may change, reduce, or discontinue any Plan benefits, in whole or in part, add or delete insurance carriers or benefit providers, at any time and for any class of participants. Moreover, the Board of Trustees may require new or greater co-payments at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.

ALERT: ONE YEAR PERIOD TO FILE A LAWSUIT

If an appeal has been denied or there has been a different form of adverse action taken, such person (Participant, Beneficiary or any other person or entity) has one year from the date of such denied appeal or adverse action to file a lawsuit against the Plan, an individual Trustee, the Board of Trustees and/or any other person or entity involved with the denied appeal or adverse action. If the person fails to do so, no lawsuit is permitted. This one-year limitation period covers any and all claims for benefits referenced in this Plan and is intended to supersede any language in this Plan document to the contrary.

I. GENERAL – RESTATED PLAN

A. ESTABLISHMENT OF PLAN.

1. Restatement of Plan: The Board of Trustees restates the Solano-Napa Counties Electrical Workers Health and Welfare Plan as of January 1, 2019. The Plan is also governed under the terms of the Trust Agreement which are the subject of good faith bargaining between the Union and the Association. All contributions to the Plan are made pursuant to collective bargaining agreements or the Electrical Industry Health and Welfare Reciprocal Agreement except as the Trust Agreement or the Eligibility rules permit contributions pursuant to a Subscription Agreement. The Plan's medical, hospital, and prescription drug benefits are offered through a health maintenance organization, which is Kaiser Foundation Health (HMO) Plan (hereafter "Kaiser"). Other benefits are provided as listed in section 5 on the next page of this booklet. The provisions of this Plan are effective as of January 1, 2019, although certain provisions may have different effective dates as noted.

The Plan is intended to be maintained for the exclusive benefit of Participants and their eligible Dependents. It is also intended that this Plan Document shall conform to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA), as that Act applies to multiemployer health and welfare employee benefit plans such as the Plan.

2. Election of Health Maintenance Organization (HMO) Benefit Option: The Board of Trustees provides the option to elect enrollment by the eligible Participant and his or her eligible Dependents in one or more Health Maintenance Organizations (HMO). Currently, the Plan offers HMO benefits through Kaiser.

An HMO uses a group of doctors and other health care professionals who emphasize preventive care and early intervention. HMO services are prepaid and a designated premium covers services. You share some costs, however, by paying a fee called a co-payment for some services and products.

To be eligible to enroll in an HMO, you must live within the HMO's service area. Moreover, services may not be covered unless preauthorized by your Primary Care Physician (PCP). For medical services to be covered you must follow the HMO procedures and you must use an HMO network provider. You are required to include a residence address (rather than a P.O. Box) when you complete your Enrollment Form. If you move out of the geographic area of the HMO, you may be required to change your coverage under the Plan. You and your family members are required to have the same coverage selection. The times and the geographic areas in which such enrollment may be open to Plan Participants will be determined by mutual agreement between the Board of Trustees and the HMO.

3. Incorporation of HMO as Part of Plan: At any time or times that the Board of Trustees enters into a new or different contract and/or renewal contract with an HMO, such contract(s) is incorporated in this Plan effective as of the date of such contract, provided same has been executed by the Board of Trustees or a duly authorized representative of the Board of Trustees.

4. Consequences of Election of HMO Plan by Participant:

a. Benefits Not Part of HMO. Benefits payable to an Employee, Participant and/or eligible Dependent(s) who has elected enrollment in an HMO shall be determined solely in accordance with the contract between the Trustees and the HMO except for Life Insurance and Accidental Death and Dismemberment (through an Insurance Company) (Actives only).

b. HMO Rules Apply. All rules and/or regulations set forth herein regarding claims review and/or appeals, shall be governed by the rules and regulations of the HMO without regard to similar rules and regulations that may be otherwise set forth in this Plan.

5. **Additional Benefits:** The Plan provides the following types of additional benefits subject to certain eligibility provisions and exclusions to eligible Participants and their Dependent(s):

a. Basic & Supplemental Life Insurance and Accidental Death & Dismemberment Benefits (supplemental life insurance $10,000 maximum) (insured through UHC) (Actives & Retirees get Supp. life) (Retirees do not get Basic life and AD&D);
b. Dental Care (insured through United Health Care PPO Dental Plan) (Active, Retirees, Dependents); and
c. Vision Benefits (insured through Vision Service Plan) (Active, Retirees, Dependents).
d. Wageworks/HRA - $3,000 individual/$6,000 family

HMO and Carrier Rules Apply. All rules and/or regulations set forth herein regarding claims review and/or appeals, shall be governed by the rules and regulations of the HMO and Carrier without regard to similar rules and regulations that may be otherwise set forth in this Plan.

B. PLAN MAY BE CHANGED.

The Board of Trustees of the Plan expressly reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time. Benefits provided under this Plan are NOT vested. The Board of Trustees expressly reserves the right, in its sole discretion, to:

1. Terminate or amend either the amount or condition with respect to any benefit, even though such termination or amendment affects claims which have already accrued;
2. Alter or postpone the method of payment of any benefit;
3. Amend, terminate or rescind any provision of the Plan;
4. Merge the Plan with other plans, including the transfer of assets;
5. Terminate any HMO or insurance company;
6. Restrict coverage to those living only in certain geographic areas;
7. Recover any amounts improperly paid including offsetting any amounts owed to the Plan against any claims that the participant and/or dependent incur in the future; and
8. Power to deny, suspend or discontinue benefits to a participant and/or dependent who fails to submit at the request of the Trust Fund office any information or proof of coverage reasonably required to administer the Plan.

The authority to make any changes to the Plan rests solely with the Board of Trustees.

C. PLAN AND OPERATION.

1. Board of Trustees Responsibilities: The Plan is administered by a Board of Trustees comprised of up to ten Trustees. One-half of the Trustees, called "Employer Trustees," are selected by the Employer Associations signatory to Collective Bargaining Agreements with IBEW Local 180 and one-half of the

Trustees, called "Union Trustees," are selected IBEW Local 180. The current Trustees are listed on page v of this booklet.

The Trustees have many powers and functions including investing the Plan's assets, interpreting Plan provisions, amending the Plan, answering policy questions, and contracting with advisors and consultants, such as an auditor, legal counsel, and investment manager.

Only the Board of Trustees and its authorized representatives are authorized to interpret the Plan's benefits described in this booklet. No one else can interpret this Plan or act as an agent for the Board of Trustees -- this includes Employers, Employer Associations, the Union and their representatives. The Board of Trustees (and persons or entities appointed or so designated by the Board of Trustees) has the full discretionary authority to determine eligibility for benefits and to construe the terms of the Plan (and other documents pertaining to the Plan and Trust) and any rules adopted by the Board of Trustees.

The Board of Trustees of the Plan is the named fiduciary with the authority to control and manage the operation and Plan of the Plan. The Board shall make such rules, interpretations and computations and take such other actions to administer the Plan as the Board, in its sole discretion, may deem appropriate. The rules, interpretations, computations and actions of the Board are binding and conclusive on all persons.

2. Standards of Interpretation: The Board of Trustees, and/or persons appointed by the Board, shall have the full discretionary authority to determine eligibility for benefits and to construe the terms of this Plan and any regulations and rules adopted by the Board. Only the Fund Manager and/or the Board of Trustees acting upon appeals properly before the Trustees shall have the authority to bind the Trustees to an interpretation of the provisions of this Plan. Nonetheless, claims and appeals for matters relating to an HMO are subject to that HMO's rules and procedures.

3. Delegation of Duties and Responsibilities: The Board of Trustees may engage such employees, accountants, actuaries, consultants, investment managers, attorneys and other professionals or other persons to render advice and/or to perform services with regard to any of its responsibilities under the Plan, as it shall determine to be necessary or appropriate.

4. Employer Contributions: Employer contributions are made to the Plan pursuant to the terms of Collective Bargaining Agreements with IBEW Local 180. Contribution rates for each hour of your Covered Employment are set, from time to time, by the parties to the Collective Bargaining Agreements. Your Employer is required to contribute only for such hours of work that are required by the Collective Bargaining Agreement. Such amounts may change at any time if agreed to by the bargaining parties.

Your Employer is required to make monthly contributions for your Covered Employment and mail such payments to the bank depository by the **15th** day of the month following the month in which your work was performed. For example: January hours generate employer contributions paid in February which are posted on the Plan's books when received but are not credited to Participants until on or about March 1st. Each monthly payment made by your Employer is accompanied by a transmittal form that contains the names, Social Security numbers, and hours of work performed by each Covered Employee together with a payment to the Plan. The Employer Contributions to the Plan are not subject to withholding for Federal Insurance Contributions Act (FICA), Federal Unemployment Tax (FUTA), or state or federal taxes.

The Plan Office checks the Employer's transmittal report for mathematical accuracy and notifies the Employer if there is any error in the Employer's computations which requires correction.

IMPORTANT NOTICE:

Notify the Union and the Plan Office immediately if you believe that your Employer has not contributed and/or is not contributing the full amount on your behalf required under your Collective Bargaining Agreement. Please refer to your dispatch as a reference.

The amount of Employer Contributions made to the Plan for non-bargaining unit employees (such as employees of the Union, the JATC, the Plan Office and others not working under a collective bargaining agreement) will be governed by individual Subscription Agreements entered into with the Plan and any rules adopted by the Board of Trustees.

5. Loss of Eligibility if no Contributions: You may lose eligibility with the Plan if Employer Contributions are not timely received by the due date for Employer contributions by the Plan Office.

6. Availability of Fund Resources: Benefits provided through the Plan Office can be paid only to the extent that the Plan has adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder, beyond the obligation to make contributions as provided in the Collective Bargaining Agreement. In the event that at any time the Plan does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any Contributing Employer to make benefit payments or contributions (other than the contributions for which the Contributing Employer may be obligated by the Collective Bargaining Agreement) in order to provide for the benefits established hereunder. There shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, the Union, Signatory Associations or other person or entity to provide benefits established hereunder if the Plan does not have sufficient assets to make such benefit payments.

7. Funding Methods and Benefits: The Board of Trustees may provide benefits either by insurance or HMO or by any other lawful means or methods upon which they may determine. The coverage to be provided shall be determined in the sole discretion of the Board of Trustees and limited to such benefits as can be purchased with the funds available.

8. Special Exclusion for Fraud/Reimbursement or Offset for Overpayment: No benefits will be paid for fraudulent claims of services or supplies or false information (including but not limited to verify disability, age, beneficiary information, marital status, enrolling an ineligible dependent, failing to notify the Plan that a previously eligible dependent no longer qualifies as a dependent, failure to timely enroll in Medicare, or other vital information) made by a Participant, eligible Dependent, or any other person. If a fraudulent claim has been paid on behalf of any person or false statements are made to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, both the Participant and any person on whose behalf a fraudulent claim or false information was submitted will be liable to the Plan for repayment. The Participant and person (including the participant or person's estate) on whose behalf a fraudulent claim was submitted will also be responsible for any attorney's fees and costs incurred by the Plan as a result of the fraudulent acts.

If a Participant or any eligible Dependent of the Participant has any outstanding liability due to fraudulently paid claims, neither the Participant nor any eligible Dependents may assign any rights to benefits to a provider of service until all fraudulently paid benefits have been repaid in full. If fraudulently paid benefits are not repaid in full, any purported assignment of benefits by a Participant or eligible Dependent may be disregarded by the Plan. However, if any payment of benefits is made by the Plan under a purported

assignment, this would not be a waiver of the right of the Plan to refuse to acknowledge other purported assignments.

If any fraudulent claims have not been repaid when a Participant or eligible Dependent incurs covered charges, the Participant or eligible Dependent shall pay all charges directly and file a claim for credit in lieu of benefits, until the entire amount of the fraudulent claims have been credited. The Plan may offset any amounts owed against any benefits that may be payable under the Plan for a Participant and/or his Dependents

In addition, any Participant or eligible Dependent who owes money to the Plan may be required to sign a written agreement before a notary agreeing to have any owed amounts deducted, offset, or paid from any death benefit, benefits payable from a life insurance company with which the Plan has a contract, or payment from any distribution from the Retirement Plan.

9. **Plan Year:** The Plan Year commences **February 1st** of each year and ends on **Jan. 31st** of the following year.

10. Non-Grandfathered Plan: The Board of Trustees believes this Plan became a "Non-Grandfathered health plan" under the federal law known as the Patient Protection and Affordable Care Act ("ACA") on September 1, 2013. As required by the ACA, a Non-Grandfathered health plan is required to provide preventive health services without any cost sharing, enhanced claims and appeals procedures, and certain other consumer protections, such as the elimination of annual and lifetime limits on the Plan's essential health benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Manager at the number listed on page v. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 1–866–444–3272 or *www.dol.gov/ebsa/healthreform.* This website has a table summarizing which protections do and do not apply to grandfathered and non-grandfathered health plans.

D. YOUR RESPONSIBILITIES.

1. Your Mailing Address: It is your responsibility to keep the Plan Office advised of changes to your address so that you may continue to receive notices of important Plan changes that may affect your coverage or continue to receive Plan information. Changes must be made in writing by completing the appropriate Enrollment Form or Change of Address Form, both of which are available on the Plan's web page for the Plan at https://www.ourbenefitoffice.com/IBEW180/Benefits. **Please note:** Kaiser will not accept a PO Box address as a mailing address or place of residence. All Plan Participants must provide a street address to enroll in either health plan.

2. Enrollment Form: Full completion and return of the Enrollment Form is mandatory for all Plan Participants for enrollment, changes and upon request by the Plan Office. You are required to complete a new Enrollment Form and submit to the Plan required proof when you have a change in life circumstances (such as a marriage, separation, divorce, birth of child, Dependent status changes, Medicare eligibility or QMCSO). All Plan Participants and Dependents must provide a street address to enroll in either Health Plan. Generally, any changes will be effective the first day of the following month after your updated Enrollment Form is received.

3. Change in Dependent Status: Keep your enrollment form updated by adding a new Spouse or Child with any required proof, such as a marriage or Domestic Partner registration certificate, birth certificate or legal adoption papers. You must also notify the Plan Office if a Dependent ceases to qualify as a Dependent, for example, due to divorce, death or the attainment of age 26.

4. Beneficiary Form: You should complete a Beneficiary Form at the time of initial enrollment. If you decide to change your Beneficiary, you must complete a new Beneficiary Form.

5. Protected Health Information (PHI): There are Privacy Rules to protect you based on the federal legislation known as the Health Insurance Portability Accountability Act of 1996 ("HIPAA"). If you wish to authorize someone other than yourself to access information from the Plan Office on your behalf, you must complete the Protected Health Information Authorization Form (available at the Plan Office) and return it to the Plan Office.

6. Identification (ID) Cards: ID cards provide information but are not a guarantee of eligibility or benefits. Eligibility and benefits are verified on a month to month basis. Depending on the Health Plan selection elected on your Enrollment Form, you will be sent a Kaiser ID card to access your Medical and Prescription Drug benefits. When you submit claims or correspondence to the Plan Office, you should include the last four digits of the Plan Participant's Social Security number. The Plan will also provide you with a WageWorks flex card that will cover you and your family for up to $3,000 for self-only coverage and $6,000 for family coverage for all medical services including co-payments, deductibles and coinsurance except for prescription drugs. Please note: Dental claims should be submitted to United Health Care Dental PPO Plan. Also, please note Vision Service Plan does not issue ID cards, please visit their website at www.vsp.com to create a login for services.

E. DEFINITIONS.

1. Active Employee. "Active Employee" means any person who meets the Plan's eligibility rules and has not suffered a termination of eligibility.

2. Association. "Association" or "Employer Association" means the National Electrical Contractors Association.

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

4. Child or Children. "Child" or "Children" means a natural child, stepchild, legally adopted child (in accordance with ERISA Section 609c) and a child who resides with an Employee for whom the Employee is the child's legal guardian pursuant to the same provision for coverage of children of the Employee, provided documentation of the court order granting the Employee guardianship over the child is provided to the Trust. The same age status requirement that apply to a natural child, stepchild, and legally adopted child also apply to a child for whom an employee is the legal guardian.

5. COBRA-Qualified Employee. "COBRA-Qualified Employee" means any Active Employee who is a Qualified Beneficiary.

6 Dependent. "Dependent" means:

(a) The Legal Spouse or Domestic Partner of an Active Employee, Retired Employee, deceased Pension-Eligible Employee, or the Legal Spouse or Domestic Partner of a deceased COBRA-Qualified Employee; or

(b) Children of an Employee, if they are:

(1) ***Child(ren) Up to Age 26.*** Younger than age 26 (coverage will be provided up to the end of the month in which the child turns age 26); or

(2) ***Disabled Dependent Child(ren).*** Age 26 or older and prevented from self-sustaining employment due to a mental or physical handicap provided such incapacity commenced prior to the date the child turned age 26 and provided that the child is dependent upon the employee for support and maintenance. Participant may be required to submit certification of total and permanent disability from a licensed physician to the Trust Fund Office within 30 days of the Dependent Child's 26th birthday and thereafter as determined by the Board of Trustees. The Board of Trustees may charger a higher rate of premium for Disabled Dependent Children over age 26, at any time. The Board of Trustees reserves the right to set an age limit on Plan coverage for Disabled Dependent children in the future and may terminate such coverage at any time.

By adopting a more inclusive definition of "Dependent" in any contract of insurance or for health care services executed by the Trust Fund, the Trust Fund does not waive its right to apply the definition of this Section under any other contract or plan of benefits, and the Trust 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.

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

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.

9. Fund. "Fund" or "Trust 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" or "Plan Office" means the office of the Fund Manager appointed by the Trustees to administer the Plan.

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.

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.

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.

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.

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.

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

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.

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

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.

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.

II. ELIGIBILITY RULES

A. ELIGIBILITY REQUIREMENTS FOR BARGAINING UNIT ACTIVE PARTICIPANT.

1. Initial Eligibility for Bargaining Unit Employees: Active Employees performing work covered by the Collective Bargaining Agreement between IBEW Local 180 and the Northern California Chapter,

NECA (ex. Residential Agreement, Inside Construction Agreement), or individual Employers who have Collective Bargaining Agreements with IBEW Local 180, and which are required to make Employer contributions to this Health and Welfare Fund, are eligible for benefits under the conditions authorized by the Board of Trustees as set forth in this document.

If you are a new bargaining unit Employee performing bargaining unit work for a contributing employer, you will become eligible for coverage under this Plan on the **first day of the second calendar month** following a **period not to exceed six months during which such person has accumulated to his or her credit, a minimum of 125 hours of Covered Employment in your hour bank**. The maximum number of hours in your hour bank may not exceed 750 hours at any given time.

EXAMPLE: You begin work for a contributing employer on March 1st. You work 100 hours in each of the first two months that follow for a total of 200 hours by the end of April. May is the lag month. Your coverage would begin June 1st. Had you worked 125 hours or more in the month of March you would have obtained initial eligibility for benefits on May 1st.

2. Continuation of Eligibility/Reserve Hour Bank: A separate reserve account, also known as an hour bank, will be maintained for each Active Employee showing an accumulation of hours worked for Contributing Employers. Once an employee is eligible to participate, the participant must work 125 hours per month in covered employment to continue his/her eligibility. The hours an Active employee works in one month will apply towards his/her eligibility for coverage in the second following calendar month. Consequently, if an Active employee continuously works 150 hours a month he/she will reserve an excess of 25 hours each month in his/her hour bank up to the maximum of 750 hours. If an Active employee does not work in a month, or if he/she works less than 125 hours in a month there will be a deduction of up to 125 hours per month from his/her hour bank to provide coverage. **The number of hours required to maintain eligibility each month could increase in the future, at the Board of Trustees discretion.**

EXAMPLE: Employee in the above example first became eligible for benefits on June 1st 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. Then 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. In accordance with Plan rules, if your Employer fails to make a contribution when it is due, your eligibility may terminate (depending on the available hours in your Reserve Hour Bank). After eligibility is lost, eligibility for prior periods may be reinstated when your Employer makes the required contribution on your behalf. 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.

Please remember that the hours you work in any given month determine your eligibility in the second calendar month following your hours worked. In addition, Employers may not always report on a full calendar month due to their specific payroll cut off. Thus, hours reported are based on ONLY those hours reported by your Employer and not necessarily all hours worked in a given calendar month. **The number of hours required to maintain eligibility each month could increase in the future, at the discretion of the Board of Trustees.**

3. Maximum Reserve (Hour Bank): You may accumulate a reserve not to exceed 750 hours, to be used in the future to supplement insufficient hours and shall have no credit for hours reported in reserve exceeding 750 hours.

4. Limits and Rules Regarding Reserve Hours—No Vested Right: Coverage for Employees is based on the accrual of hours at the current contribution rate, determined by the Board of Trustees, for the accumulation of hours in a Participant's Reserve Hour Bank. Hours are credited for actual work hours in a particular month. Thus, hours reported late because of late contributions, reciprocity or because of insufficient payments discovered through a payroll audit may not increase your Reserve Hour Bank.

You do not have a vested right to your Reserve Hour bank. The Board could reduce and/or cancel these hours at any time. In addition, Employers do not always report on a full calendar month due to their specific payroll cut offs and therefore hours reported are based on ONLY those hours reported by your Employer and not necessarily all hours worked in a given calendar month.

5. Types of Coverage Available: The Plan will provide the following categories of benefits for the classifications indicated, as more specifically described in the most recent agreements between the Plan and its insurers and health care providers. All benefits are subject to modification or termination. Please contact the Trust Fund Office for the most current list of coverage options available.

(i) Active Employees Under the Residential Agreement. For active employees under the Residential Agreement, coverage includes hospital, medical, mental health/substance abuse, prescription drugs, life insurance, AD&D, dental and vision benefits.

(ii) Active Employees Under the Inside Construction Agreement. For active employees under the Inside Construction Agreement, coverage includes hospital, medical, prescription drugs, mental health/substance abuse, life insurance, AD&D, dental and vision benefits.

6. Reciprocity/Eligibility Procedure for Reciprocity Work Hours: When you, as an IBEW Local 180-member, work outside the IBEW Local 180 area, you may request that your Health and Welfare Employer contributions be transferred to this Plan. In order to help you establish or continue health and welfare eligibility through accumulation of hours in your hours' bank when working under a reciprocity agreement, the following options are available for crediting hours that have not been paid or reported to this Trust Fund office.

Reciprocity hours usually take an extra month to be received by the Solano-Napa Counties Electrical Workers Health & Welfare Plan (the "Plan") from the reciprocal Trust Fund. The hours are received and entered by the reciprocal Trust Fund the month after they are worked by you unless they are delinquent. Then the reciprocal Trust Fund forwards the hours and contribution amount usually by the end of the following month to this Plan's Trust Fund Office.

Because the reciprocity process could cause delay which may result in a loss of coverage or failure to establish coverage you should call the Trust fund Office and advise them of hours worked out of area and fax check stubs or identify your employer. The Trust Fund Office can verify and credit your account before the dollars/hours are actually transferred.

For example: Hours worked in January are received by the reciprocal Trust Fund in February which should be applied to your March eligibility. The reciprocal Trust Fund actually sends the hours/employer contributions to this Trust Fund by March. Because the hours are not in the system when eligibility for March is calculated (at the end of February), the system reads it as though you have not yet established or continued your eligibility. This may result in the Plan sending you a self-pay notice/COBRA notice you may or may not actually owe to the Trust Fund.

The following is the procedure you can follow to help obtain eligibility while working reciprocity hours:

1. Before the end of a work month, contact the Trust Fund Office and advise of them of the hours you worked for your employer. The Trust Fund Office will contact the reciprocal Trust Fund. If they can confirm that they have received payment for a sufficient number of hours and are in the process of transferring a payment to this Trust Fund, your eligibility can be manually entered and self-pay and COBRA notices can be pulled. Please note that the contribution rate may be lower/higher in the reciprocating local and will need to be pro-rated when received by this local. If lower, not every hour worked will apply to eligibility.
2. However, if the employer has not paid timely, please provide the Trust Fund Office with your check stubs for purposes of verifying your eligibility for Health and Welfare, if the hours were worked due to reciprocity. (Check stubs must supply Health & Welfare hours and rate of contribution).
3. You can submit a self-payment once you receive a self-payment notice. In the event that a sufficient amount of reciprocity hours is received for that month's eligibility, your payment will be entered into a savings bank for a future month of loss coverage.
4. **It is important to understand you can only reciprocate to your home local fund (the health fund covering the jurisdiction of the local where you are a member) or the local where you are working.** For example, if you are a Local 180 member working in San Francisco you can leave your contributions with Local 6 or reciprocate them back to Local 180 (Solano Napa Electrical Workers Health and Welfare Fund). If you leave San Francisco and go to work in Contra Costa County (Local 302) you can leave contributions in Local 302's trust funds or send them back to Local 180. You cannot reciprocate to Local 6 while you work in Local 302 jurisdiction if you are a Local 180 member.

7. Termination of Eligibility: An Active employee's eligibility for benefits will terminate on the earliest of the following dates:

a. On the last day of the calendar month on which he/she has fewer than 125 hours in his/her hour bank (including Employers failure to make a contribution when it is due).
b. On the last day of the month following entry into full-time military service.

B. ELIGIBILITY REQUIREMENTS FOR NON-BARGAINING UNIT ACTIVE PARTICIPANT.

1. Eligibility for Non- Bargaining Unit Employees: An Employer contributing to the trust for bargaining unit employees (active employees) may include, by executing a subscription agreement, non-bargaining unit employees subject to the following rules:

a. All such employees in this category (non-bargaining unit employees) except those working less than a hundred (100) hours per month must be covered.
b. Contributions must be received by the twentieth of the month prior to the month for which coverage is desired.
c. The Employer must agree to adopt this Plan and the Trust agreement under which it operates.
d. 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 calendar days of continuous fulltime employment (100 hour per month employment).
e. 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.
f. Non-bargaining unit employees do not have a reserve hour bank account accumulation.

g. 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.

C. DEPENDENT ELIGIBILITY REQUIREMENTS

1. Lawful Dependent Spouse: Your lawful spouse (husband or wife including a same sex spouse) is an eligible Dependent under the Plan. In the event of marriage, coverage is effective the date of marriage, provided that you have submitted an Enrollment Form and copy of your certified marriage certificate within 30 days of the date of marriage. If proper documentation and your Enrollment Form is not received within 30 days of the date of marriage, enrollment of your Spouse will not be effective until the first of the month following receipt of the required documents. **California law and this plan do not recognize common law marriage; however, you and your partner may qualify as Domestic Partners. Please Refer to Subsection 2 below for additional information regarding Domestic Partner eligibility and benefits.**

2. Domestic Partners: An eligible and covered participant's Domestic partner will be covered provided the Domestic partner status complies with the domestic partner laws of your state or domicile or the city and county of San Francisco, California. 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 Trust Fund, then those contract provisions shall govern for purposes of interpreting who is entitled to medical coverage.

In addition to the above requirements, both the Covered Participant and the Domestic Partner agree to inform the Trust fund Office of the termination of their domestic partnership as a result of a change in one or more of the above requirements or the death of the domestic partner. It is the Participant's responsibility to notify the Fund Office once a Domestic Partner no longer meets the Plan's Domestic Partner eligibility requirements. A Participant who fails to notify the Fund Office within 30 days of the date that a Domestic Partner has a change in eligibility status will be legally responsible for any payments or premiums made by the Plan from the date the Domestic Partner became ineligible for coverage. Eligibility of a Domestic Partner shall terminate on the date the Domestic Partner no longer meets the Plan's eligibility requirements including lack of timely payment of the imputed income taxes.

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

Proof of Continuing Eligibility. The Plan may require evidence of continued domestic partnership status at any time.

3. Dependent Child(ren): Your eligible Dependent Child(ren) are your natural children, (legally adopted children, stepchildren, and child(ren) for whom the Participant has Court-Appointed Legal Guardianship. Your children are eligible for coverage through age 25 (up to the end of the month in which the child attains age 26). Disabled Child(ren) age 26 or older prevented from self-sustaining employment due to a mental or physical handicap may also qualify as dependents provided such incapacity commenced

prior to the date the child turned age 26 and provided that the child is dependent upon the employee for support and maintenance. Participant may be required to submit certification of total and permanent disability from a licensed physician to the Trust Fund Office within 30 days of the Dependent Child's 26th birthday and thereafter as determined by the Board of Trustees. The Board of Trustees may charger a higher rate of premium for Disabled Dependent Children over age 26, at any time. The Board of Trustees reserves the right to set an age limit on Plan coverage for Disabled Dependent children in the future and may terminate such coverage at any time.

By adopting a more inclusive definition of "Dependent" in any contract of insurance or for health care services executed by the Trust Fund, the Trust Fund does not waive its right to apply the definition of this Section under any other contract or plan of benefits, and the Trust Fund may continue to do so notwithstanding the terms of any other such contract.

4. **Enrollment of Dependents/Your Responsibility:** Upon enrollment, Dependents become eligible for coverage on the later of the following two dates: (a) when a Participant's eligibility is effective or (b) when he or she qualifies as an eligible dependent through legal marriage, domestic partnership, birth or adoption, as the case may be. When completing an Enrollment Form you are indicating that the Dependents listed meet all requirements listed above**.**

IMPORTANT. You must inform the Trust Fund office within 30 days of adding a new dependent. If you fail to notify the Trust Fund Office within 30 days following the addition of a new dependent, should you subsequently enroll your dependent's coverage will not become effective until the first of the month after you have applied and provided any necessary documentation to establish their eligibility as a dependent. This will result in a delay in eligibility for benefits. You are also required to notify the Trust Fund Office of a dependent's change in eligibility status. Failure to do so may be considered fraud and could result in a request for reimbursement of any overpayments; and/or loss of certain extensions of coverage (i.e., COBRA) for the ineligible Dependent. The Plan reserves the right to periodically request supporting documentation or written verification that an enrolled Dependent continues to meet Plan Dependent requirements (i.e. written confirmation and/or documentation that a spouse still resides with you etc.).

WARNING ABOUT FRAUD AGAINST THE PLAN/CHANGES IN DEPENDENT STATUS – NOTIFY THE TRUST FUND OFFICE

It is the Participant's and/or dependent's responsibility to notify the Trust Fund Office immediately when a Dependent's status changes. This includes a divorce/final dissolution of marriage, legal separation, a Dependent child over 25 and any other events which would no longer make your dependent eligible for coverage. If claims are paid for, or premiums are paid on behalf of, any Dependent spouse or child and it is later found that the dependent was not eligible, **you and the Dependent will be responsible for reimbursing the Plan for the actual amount paid out in benefits by the Trust plus interest and any costs and attorney's fees incurred by the Plan as a result of maintaining an ineligible Dependent.**

5. Termination of Dependent Coverage. A Dependent's eligibility will terminate on the earlier of the following:

a. when the Participant loses eligibility or upon Participant's death (however eligible dependents of pension-eligible retirees may continue coverage under circumstances described in Article III), or
b. when the individual ceases to meet the Plan's definition of an eligible Dependent.

You must notify the Trust Fund Office in writing within thirty (30) calendar days, when an eligible Dependent ceases to meet the definition of an eligible Dependent and stating the reason for termination of eligibility or Dependent status.

6. Automatic Coverage for a Newborn Child- If Plan Notified Within 31 Days: A newborn or newly adopted child will automatically be covered for the first 30 days of medical benefits on the date the child becomes a Dependent. However, you are required to apply for Dependent coverage for that child within 30 days of the child's birth or of the adopted child's placement in your home in order to continue that child's coverage beyond the first 30 days. You are urged, however, to enroll the new child immediately.

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

7. Types of Coverage Available: The Plan will provide the following categories of benefits for the classifications indicated, as more specifically described in the most recent agreements between the Plan and its insurers and health care providers. All benefits are subject to modification or termination. Please contact the Trust Fund Office for the most current list of coverage options available.

(i) Active Employees Under the Residential Agreement. For Dependents of active employees under the Residential Agreement, coverage includes hospital, medical, mental health/substance abuse, prescription drugs, dental and vision benefits.
(ii) Active Employees Under the Inside Construction Agreement. For Dependents of active employees under the Inside Construction Agreement, coverage includes hospital, medical, prescription drugs, mental health/substance abuse, dental and vision benefits.

D. SPECIAL ENROLLMENT RIGHTS.

Other than during Open Enrollment, the Plan is required to provide Special Enrollment Rights to you and your eligible Dependents upon the following events:

1. Loss of Other Coverage: If you did not enroll yourself and/or your eligible Dependents because you and/or your Dependents had other group health coverage or other health insurance, including COBRA continuation coverage, and showed the Plan Office evidence of such other coverage, you and/or your eligible Dependents may enroll in this Plan during a Special Enrollment period. This Special Enrollment period is a 30-day period which begins when you lose the other coverage. To take advantage of this Special Enrollment Right, you and/or your Dependents must enroll in the Plan within 30 days of exhausting COBRA continuation coverage or the termination of such other coverage as a result of a loss of eligibility for coverage (such as a divorce, legal separation, death, termination of employment, reduction in the number of hours, ceasing to reside, live or work in the HMO service area if no other coverage is available under the other plan, or dependent ceasing to qualify as a dependent under the other plan).

2. Acquire New Dependents: Newly acquired eligible Dependents, including your legal spouse, newborn, adopted child(ren) or step child(ren), will be covered from the time of birth, adoption, placement for adoption, or marriage provided you complete and submit an Enrollment Form and appropriate documentation to the Plan Office within 30 days of the birth, adoption, placement for adoption, or marriage.

3. Special Enrollment Allowed Under The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP): The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) created a special enrollment period that applies to group health plans, similar to those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes. Under this Act, group health plans must permit yourself and/or your eligible dependents with group health plan coverage to enroll in the Plan if they:

- Lose eligibility for Medicaid or CHIP coverage; or
- Become eligible to participate in a premium assistance program under Medicaid or CHIP

In both cases you and/or your eligible dependent must request special enrollment within 60 days (of the loss of Medicaid/CHIP or gaining eligibility for premium assistance under Medicaid or CHIP, as applicable. More information is available at *www.coveredca.net* or *www.dhcs.ca.gov/services/medi-cal*.

III. RETIREE ELIGIBILITY

If you are a retired employee under the Inside Construction Agreement you may be eligible for benefits, provided you meet the requirements 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. The Board of Trustees established retiree medical benefits on the basis that Employer contributions for Active Participants will, if continued, partially maintain benefits for retirees. You will be required to pay a portion or all of the cost of coverage for retiree benefits. Retirees eligible for retiree coverage are required to pay a monthly premium to the Plan based on the Medicare status of the retiree and other eligible enrolled Dependents.

It is recognized that the benefits provided by this Plan can be paid to the extent that the Plan has available adequate resources for those payments. You should contact the Trust Fund Office for current rates. **The Board of Trustees may change the rates at any time. Benefits under this Plan are not vested and can be changed or eliminated at any time. Monthly premium payments for Retirees are likely to increase.**

A. ELIGIBILITY RULE.

1. Eligibility Rules – Retirees. Retired employees may be eligible for benefits provided: (a) you have attained age 55 or are currently receiving a Social Security Disability Retirement benefits based on total and permanent disability, (b) you are receiving a pension under the Solano-Napa Counties Electrical Workers Pension Plan on the basis of not less than 10 years of vested service without a permanent break in service, (c) 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 (e) you make the required self-payment contribution. **There currently is a charge for the Retiree benefits. These rules only apply to retirees who performed work under the Inside Construction Agreement between the Solano and Napa Counties Branch, Northern California Chapter NECA and IBEW Local Union 180.**

2. Coverage Date. 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: (a) first day of the month coinciding with your annuity starting date under the Solano-Napa Counties Electrical Workers Pension Plan; or (b) first day of the month following the date in which you submit a Social Security Disability Award letter; or (c) date that your eligibility as an active employee terminates; or (d) the first day of the month following the month in which your application for benefits is submitted to the Trust Fund.

3. Totally and Permanently Disabled. A Participant who otherwise qualifies for early or regular retirement (except for reaching age 55), who becomes or is Totally and Permanently Disabled as determined by the Social Security Administration at any age, shall be eligible for retiree medical benefits under the Plan upon paying the required premium established by the Board of Trustees**.**

4. Eligibility Rules – 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:

a. The date your eligibility terminates for reasons other than by death; or
b. The date your dependent ceases to be a dependent.

You must notify the Trust Fund Office in writing within ten (10) calendar days, when an eligible Dependent ceases to meet the definition of an eligible Dependent and stating the reason for termination of eligibility or Dependent status.

Special provisions governing the eligibility of surviving dependents of deceased retired employees are described in Subsection D.

5. Types of Coverage Available to Retirees. For eligible Retirees who performed work under the Inside Construction Agreement, coverage includes hospital, medical, prescription drugs, mental health/substance abuse, dental and vision benefits, and supplemental life benefits. Retirees are not eligible for basic life and accidental death and dismemberment benefits under the Plan. Benefits are not provided for service under the Residential Agreement for retired employees. Please contact the Trust Fund Office for the most current list of coverage options available.

B. 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 right to change the rates in their discretion and to discontinue any subsidy that the Plan otherwise provides. This subsidy is being reduced annually. THESE AMOUNTS MAY INCREASE IN MOST IF NOT ALL YEARS.**

The initial payment shall be due within 45 days after the date of your retirement and dependent continuation of benefits application is received by the Trust Fund Office by the deadline required under Section A.2 above) Subsequent payments shall be made in monthly installments due on the 20th of the month prior to the month of coverage. Payments made later than 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.

C. MEDICARE COORDINATION--YOU ARE REQUIRED TO ENROLL.

1. Summary of Medicare. Medicare is our country's federal health insurance program for people who worked at least 10 years in Medicare Covered employment who are age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income (SSDI) benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin. If you are not a citizen or permanent U.S. resident, you may not qualify for Medicare. **If you or your Spouse becomes eligible for Medicare, you should carefully read this section. It will tell you what your obligations are concerning enrolling in Medicare Part A and B, how the Plan pays when you are eligible for Medicare, and other important information you need to know.**

Medicare has four parts:

- **Medicare Part Hospital Insurance**. Part A covers inpatient care and certain skilled nursing facilities. Generally, there is no monthly premium, but there are annual deductibles and co-insurance/co-payments after certain lengths of stay.
- **Medicare Part B – Medical Insurance**. Part B covers medical and doctor services, outpatient hospital care and other services. Part B requires payment of a monthly premium, as well as deductibles and co-insurance/co-payments. The member pays an annual deductible and 20% coinsurance. Members continue to pay the Part B premium monthly out of their Social Security check.
  You should enroll in Part B when first eligible to avoid a financial penalty and a potential delay in your enrollment.
- **Medicare Part C – Medicare Advantage Plans**. Health plan options approved by Medicare and administered by private companies.
- **Medicare Part D – Prescription Drug Coverage**. Provided through plans run by insurance companies or other private companies approved by Medicare. There are monthly premiums, deductibles and co-insurance/co-payments.

If a person declines Part B when first eligible, the cost of enrolling in Part B at a later date may be increased by 10% for each full 12-month period that they should have had Part B. The Part B penalty can be waived if a person is still actively employed or their spouse is actively employed and the person has health insurance coverage under an employer/union group health care plan (the employer must have more than 20 employees)

Medicare Part A is financed by payroll taxes, and, if you are eligible to receive it based on your own or your spouse's employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage. Most people are entitled to Part A when they turn age 65 and pay no premium because they or a spouse paid Medicare taxes while working.

The Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) such as hospital inpatient care and skilled nursing facilities (but not custodial or long-term care) and Part B (medical benefits such as medical and doctor services, outpatient hospital care and other services). **This means you must enroll in both Medicare Part A and Part B, as soon as you are eligible for Medicare. If you do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid and you will be required to pay an additional Retiree Health and Welfare Premium.**

IMPORTANT NOTICE: ENROLL IN MEDICARE

To be eligible for Retiree Health and Welfare benefits under this Plan you and/or your eligible Dependent(s) are required to enroll in both Medicare Parts A and B and pay the required premium (for part B) as soon as you and/or your eligible Dependent(s) are entitled to coverage. The Plan coordinates benefits with Medicare as if you are covered under Part A Part B, and Part D. Part D provides prescription drug coverage. You must enroll in Part B to be eligible for Part D prescription drug coverage.

MEDICARE IS PRIMARY COVERAGE FOR RETIREES. PLAN BENEFITS ARE SECONDARY. THIS MEANS THAT THE PLAN PAYS ONLY WHAT MEDICARE DOES NOT COVER. FAILURE TO APPLY FOR MEDICARE WILL SIGNIFICANTLY REDUCE THE TOTAL AMOUNT PAID TOWARD YOUR MEDICAL EXPENSES!

It is important that you enroll in Medicare Part B when you first become eligible. If you do not, Medicare generally imposes penalties which will significantly increase your Part B premium once you do enroll. The cost of Medicare Part B premium will go up 10% for each full 12-month period an individual was eligible for Medicare Part B during the initial enrollment period but did not enroll. If you did not enroll when first eligible, and later choose to enroll, you must wait until the next Medicare Part B open enrollment period, which is January 1 through March 31 of each year. Your Medicare Part B will be effective on July 1 of the year you enroll. **For enrollment and eligibility information, you should call Social Security at (800) 772-1213. You can also find Medicare information on the Internet at www.medicare.gov.**

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

> **EXAMPLE:** Below is an example of why it is important for Medicare-eligible individuals to enroll in Medicare Part B coverage.
>
> *Assume Bob, a Medicare-eligible Retiree, requires a medical service and most physicians charge $150.00 for it. Assume that Medicare's allowed amount for the services is $100.00, that Medicare would pay 80% of the allowed amount and that the Plan would pay the 20% co-insurance. If Bob is enrolled in Medicare Part B, and has satisfied the Part B deductible, the Plan would pay $20.00 because Medicare would have paid $80.00, and the claim would be considered paid in full. However, if Bob is eligible for but not enrolled in Medicare Part B, then the Plan will still pay $20.00 and Medicare will pay nothing. Consequently, Bob is responsible for $130.00 ($150.00 minus $20.00 paid by the Plan).*

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

Effective January 1, 2006, Medicare eligible individuals were given the option of enrolling in the Medicare Part D prescription drug program. Prescription drug coverage in the Plan is not affected by the Medicare Part D prescription drug program and **it is not necessary for you to enroll in Medicare Part D**. The

prescription drug benefits you currently receive under this Plan provide better coverage, at less cost to you, than the new drug program under Medicare Part D. As long as you are eligible for a prescription drug plan that has coverage that is equal to or better than what is offered under Medicare Part D, you are considered to have "Creditable Coverage"; therefore, if at some later date you choose to enroll in Medicare Part D, you will not be charged a late penalty for delayed enrollment.

D. SURVIVING DEPENDENT COVERAGE.

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.

An application to continue dependent coverage must be made within 90 days following the employee's death, along with the required initial monthly payment. An application on behalf of a minor child can be made by the child's parent or legal guardian. Subsequent monthly 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 (or surviving dependent of deceased COBRA-Qualified employee) will terminate on the earliest of the following dates:

(i) For a surviving spouse, on the date he or she remarries;
(ii) For a non-spousal dependent, on the date he or she ceases to meet the Plan's definition of a "dependent."
(iii) For all dependents, the failure to make a timely self-payment.
(iv) For Surviving Dependents of Deceased COBRA-Qualified Employee, on the date twelve (12) months after the date on which the COBRA-Qualified Employee dies and his/her Hour Bank is reduced to less than 125 hours.

E. OUT OF AREA RETIREE 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 are planning to move, you should contact the Trust fund office in advance to obtain information regarding how your new address may affect your Retiree health and welfare benefits.

If you are a retiree that resides outside of Kaiser's service area, the Plan will no longer reimburse you for your own purchase of medical coverage. Instead, you may be eligible to enroll in the Plan's United Health Care PPO option. Out of area retirees will also be entitled to dental, basic life insurance, AD&D and supplemental life insurance benefits. Please contact the Trust Fund Office for more details on coverage including any premium amounts you are responsible for. The below cost sharing amounts may change at any time, please contact the Trust Fund office for complete details.

UNITED HEALTH CARE GROUP RETIREE PPO PLAN OPTION – out of area retirees		
Annual Deductible	**None**	
Out-of-pocket Maximum (combined for in and out-of-network services)	**$1,500**	
	In -Network	**Out-of-Network**
Primary Care Visit	$10 copay	$10 copay
Preventive Services	No Charge	No Charge
Specialist Visit	$10 copay	$10 co-pay
Inpatient Hospital Stay (per admission)	No Charge	No Charge
Outpatient Surgery	$10 copay	$10 copay
Outpatient Hospital Services	$10 copay	$10 copay
Inpatient Mental Health Services	No Charge (Limited to 190 days)	No Charge (Limited to 190 days)
Outpatient Mental Health Services	$10 copay/individual visit $5 copay/group visit	$10 copay/individual visit $5 copay/group visit
Physical Therapy & Speech/Language Therapy	$10 copay	$10 copay
Outpatient Rehabilitation Facility (CORF)	$10 copay	$10 copay
Skilled Nursing Facility Care	No Charge (Limited 100 days)	No Charge (Limited to 100 days)
Emergency Room	$50 copay (waived if admitted)	$50 copay (waived if admitted)
Ambulance Services	No Charge	No Charge
Urgent Care	$10 copay	$10 copay
Home Health Care services	No Charge	No Charge
Diagnostic Lab, X-ray & Radiology Service	No charge	No Charge
Durable Medical Equipment	No charge	No Charge
Routine Hearing Exam	No Charge (every 12 months)	No Charge (every 12 months)
Hearing Aid Allowance	$500 (combined)	
Part D Prescription Drug Plan	**In -Network**	
Retail Prescription Drugs Generic	$10 copay	

Preferred Brand	$20 copay
Non-Preferred Brand	$35 copay
Specialty	$35 copay
Preferred Mail Order Drugs (up to 90-day supply)	
Generic	$20 copay
Preferred Brand	$40 copay
Non-Preferred Brand	$70 copay
Specialty	$70 copay

F. 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.

G. NOTICE TO THOSE ELIGIBLE FOR MEDICARE PART D (Prescription Drug).

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

A Notice (titled "Notice of Medicare Part D Creditable Coverage") containing general information about Medicare Part D coverage and this Plan is required to be provided to you (a Medicare eligible individual) by the Plan prior to each annual Medicare Part D enrollment period beginning November 15, 2005. The Notice must also be provided to you prior to your initial enrollment period for Medicare Part D coverage, prior to the effective date of your enrollment in this Plan, whenever the Plan's prescription drug coverage ends or changes so that it is no longer considered "Creditable Coverage", and upon your request. "Prior to" means within 12 months before the event in question. "Creditable Coverage" means that the prescription drug plan offered by the Plan Sponsor is as generous as or more generous than the standard coverage under Medicare Part D prescription drug benefit. In other words, the expected value of claims paid under the plan is as much as the value of claims that would be paid under the standard Medicare Part D benefit.

The Board of Trustees of this Plan intends to continue to provide a prescription drug benefit that is equivalent on a gross basis to Medicare Part D coverage, in other words Creditable Coverage. Therefore, there is no requirement that you enroll in Medicare Part D when you become eligible. The Plan will notify you if this changes.

IV. SELF-PAYMENTS (Prior to COBRA)

To maintain continuous coverage, a Participant whose coverage has terminated or has insufficient hours for coverage, may elect to pay for continued coverage under one of the following two options:

A. <u>OPTION ONE: Subsidized Self Payment Option – Up to 12 Months.</u>

If your eligibility terminates because of a lack of hours in your hour bank, you may make self-payments (or "buy-up" to extend coverage for yourself (and for your eligible dependents) for up to twelve months by paying the difference between the required 125 hours of work contributions for coverage from your hour bank and the hours available to you in your hour bank. Self-payments are part of your COBRA continuation 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.*

Effective November 1, 2018, the rate was $12.30per required hour and the maximum you would be required to pay would be $768.90. Please contact the Trust Fund Office for the current self-payment hourly rate as the monthly rates are subject to change at any time. You may use your VEBA supplemental accumulated share (SAS) account balance to pay this buy-up. However, you must use your hour bank first. If you choose not to pay this buy-up, your coverage will terminate and you will be offered COBRA continuation coverage at the full COBRA rates. On the occasion that you do not have any new hours reported and have no hour bank available for use, your coverage will terminate and you will be offered the opportunity to make self-payments to extend your coverage for up to 12 months.

In order to be eligible for self-payments the following limitations apply:

1. Unless your employment is precluded by a medical disability and proof of application for a Social Security Disability Retirement Benefit is submitted, 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 (you must be on the out of work list).
2. 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**.
3. Payments must be continuous for as long as the employee is ineligible.
4. Payments must not be made for more than 12 consecutive calendar months unless the employee (a) submits proof of application for a Social Security Disability Retirement benefit, (b) is not currently employed due to a medical disability and (c) makes application for self-payment within six (6) months of the onset of the disability. The opportunity to make self-payment will terminate if immediately (a) upon notification of denial of Social Security Disability benefits at the Reconsideration level, (b) if you appeal the Reconsideration, denial at the Hearing level or (c) your return to work, whichever is earliest.

For eligible surviving dependents of deceased COBRA-qualified employees, coverage will terminate on the date 12 months after the date on which the COBRA-qualified employee dies and his/her hour bank is reduced to less than 125 hours.

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.

B. OPTION TWO: COBRA Option.

You may elect COBRA continuation coverage. For details, see the COBRA coverage below.

V. CONTINUATION OF COVERAGE RIGHTS

A. COBRA CONTINUATION OF COVERAGE RIGHTS.

1. Eligibility for COBRA. A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), requires that group health plans offer covered Employees and their Dependents the opportunity to elect to pay a temporary extension of health coverage (called "Cobra Continuation Coverage" or "COBRA") in certain instances (called "qualifying events") where coverage under the Plan would otherwise end. To receive this continuation coverage the Employee, spouse and/or Dependent(s) must make timely monthly payments (including the stub payment form) directly to the Plan (or, the Bank Depository if so designated by the Plan Office).

When you no longer have sufficient hours in your Reserve Hour Bank, your COBRA coverage will run concurrently with any continuation of coverage described in section B on page 40. **In other words, your COBRA extension period is reduced by the number of months under the Active Subsidized Self-Pay coverage.**

Even if you do not elect COBRA continuation coverage, your spouse and each of your eligible dependents have a separate right to elect it. You, your spouse and your eligible Dependents should read this section of your benefit booklet. To receive this COBRA coverage, a Participant end/or his eligible Dependents must file a timely application following the qualifying event and make monthly self-payments in an amount determined by the Board of Trustees directly to the Bank Depository (designated by the Plan Office), including the payment stub.

2. Qualifying Events. If your health coverage terminates due to any of the qualifying events shown below, you and your eligible dependent may elect COBRA continuation coverage for the maximum continuation period below. A Qualifying Event is any of the following:

1. The death of the Active Participant or Retiree;
2. The Participant's termination of employment (except for gross misconduct);
3. A reduction in the Participant's hours (ex. participant has fewer than 125 hours in his/her hour bank on the last day of any calendar month);

4. The divorce or legal separation of the Active Participant or Retiree and his/her spouse; or
5. A dependent child no longer meets the definition of a Dependent.
6. The Active Participant or Retiree becomes entitled to Medicare.

3. COBRA Maximum Continuation Period rules. Upon payment of the required monthly premium (which is usually set at 102% of the applicable cost of medical coverage), you and/or your dependent(s) may elect COBRA continuation coverage and coverage will end before 18-month, 29-month or 36-months as follows.

a. Termination of Employment or Reduction in Hours. A Participant or dependent may elect COBRA for a period of up to 18 months if you lose your health coverage because of termination of your Covered Employment or a reduction in hours (including having used all hours in your Reserve Hour Bank), unless such termination is due to your Gross Misconduct. This 18-month period is reduced by the number of months of Active Subsidized Self-Payment.

   By electing COBRA continuation coverage, you will be electing to maintain benefits on behalf of your eligible Dependents. If you do not elect COBRA continuation coverage, your spouse may independently elect such coverage on behalf of himself or herself and eligible Dependents if applicable and pay the required premium.

b. Disability-Extended Coverage (for 29 months). For an additional premium and subject to certain notice provision, an Employee or other eligible Dependent may elect continuation coverage for an additional 11 months if the Employee or eligible Dependent is determined by the Social Security Administration to be totally disabled and permanently disabled as of the date of the Employee's termination or employment or reduction in hours (i.e., the qualifying event which invoked COBRA coverage) or within sixty days of the COBRA coverage. You pay 150% of the applicable premium for the additional 11 months of coverage. To qualify for this special extended COBRA eligibility, **you must report** the Social Security disability determination to the Plan Office before the initial 18 months of COBRA coverage expires and within 60 days after receipt of the Social Security determination. This disability extension ends immediately if the disabled individual recovers. **You or your dependent must also notify** the Trust Fund office within 30 days after the Social Security Administration determines that your or your dependent is no longer disabled).

c. Dependent Coverage (for 36 months). A Dependent spouse or child who would otherwise lose health coverage is eligible for continuation coverage for up to 36 months because of the following qualifying events:

   (1) The death of the Employee;
   (2) Divorce or legal separation of the Employee and spouse; or
   (3) A child ceases to meet the Plan's definition of Dependent.

d. Multiple Qualifying Events- Extended 36-month coverage. An 18-month period of COBRA continuation coverage may be extended for up to 36 months for your spouse or Dependent child if a second qualifying event occurs (such as if you die, divorce, you become entitled to Medicare, or your child no longer qualifies for coverage) within the first 18-month period. In no event, however, will such coverage extend beyond 36 months from the date coverage was first lost due to the initial qualifying event.

EXAMPLE: A Participant's Spouse is on COBRA continuation coverage due to the Employee's termination of employment. The Participant passes away after 12 months of coverage during the 18-month period. His or her death is a second "qualifying event" and entitles the spouse to the remaining balance of 24 months (36-month maximum minus the 12 months that has already been covered).

The period of coverage under this section is reduced by any period in which the Employee or dependent was provided coverage by the Plan at lower cost than coverage under this section pursuant to the subsidized self-pay provisions of the Plan.

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

4. Election of COBRA Coverage/Type of Benefits. Within 60 days after the Plan Office is informed in writing of an event entitling you and/or your Spouse or Dependent child(ren) to COBRA coverage, the Plan Office will provide you with information concerning the coverage available and its cost. You and/or your dependent(s) must elect COBRA coverage within 60 days after your coverage under the Plan ends or the date you receive the election form, whichever is later. Anyone electing COBRA coverage must pay for it retroactive to the date he or she lost coverage under the Plan. Payment for this retroactive coverage is due within 45 days after the date COBRA coverage is first elected. After this first premium, there is a 30-day grace period for making future COBRA payments. No benefit claim will be honored unless the required payment has been received for the period in which the claim was incurred.

If you elect COBRA, you will be entitled to the same health coverage that is provided to active employees or family members in the Plan. Therefore, if there are any changes to the Plan for active employees, your benefits will also change.

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 and prescription drug benefits only.
- *Core Plus Non-Core Benefits* – Medical, prescription drug benefits, dental and vision benefits.

5. 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.

6. Your Obligation to Notify Trust Fund Office. You are required to notify the Plan Office (within 60 days following the occurrence of one of these events (1) if you become divorced or legally separated from your spouse or (2) if there are any other changes in life circumstances that may affect your eligibility for benefits or those of a Dependent (ex. dependent child ceases to be a dependent under the terms of the Plan or Social Security Administration makes a determination that you or your dependent spouse is permanently and totally disabled as of the date of termination of reduction of hours that became a Qualifying Event). If you

are eligible for extended COBA coverage, you must notify the Trust Fund office within 30 days of a determination by the Social Security Administration that you or your dependent spouse is no longer disabled.

Plan Participants are also required to immediately notify the Trust Fund Office if your spouse or other enrolled Dependent no longer resides with you. Once a Dependent (including a spouse) no longer resides in your home, that Dependent would no longer meet the definition of an eligible dependent. Consequently, that Dependent would not qualify for coverage under the Plan. A spouse who does not reside with you, is no longer entitled to coverage under the Plan. Please be aware that a spouse no longer residing in the Participant's home, without a legal separation or divorce, is not a qualifying event under COBRA.

7. Termination of COBRA Coverage. COBRA continuation coverage will end before the 18-, 29- or 36-month continuation coverage period expires if:

a. Failure to Timely Pay Premium: You and/or your Dependent(s) fail to pay the required contribution on time;

b. Coverage Under Other Plan: You or your dependent(s) become covered by another group health plan after your COBRA election (except a plan that excludes or limits benefits for a pre-existing condition affecting you or your Dependent and such exclusion or limitation is enforceable under the Health Insurance Portability and Accountability act (HIPAA); or

c. Medicare Entitlement: You and/or your Dependent(s) become entitled to Medicare after having elected COBRA; or

d. No Longer Disabled: You or your Dependent(s) qualified for 29-month maximum continuation period based on disability, but are no longer disabled; or

e. Employer No Longer Contributes: Your Employer who contributed on your behalf ceases to be contributing employer; or

f. No Active Plan: The Plan and your employer cease to maintain any health plan for active employees or retirees.

B. Continuation of Coverage During Military Service (USERRA).

Under the Uniform Services Employment and Re-employment Rights Act ("USERRA"), your Employer must offer to continue coverage for you and your Dependents up to 24 months while you are on military leave of 31 days or more. Thus, if you enter full-time military service for a period in excess of 30 days, your coverage will terminate immediately. You may then purchase continuation coverage for you and your dependents under the rules included in the COBRA section described on page 31. You should notify the Plan Office if you enter military service for more than 30 days. However, you may elect to waive your rights under federal law. The months of coverage so applied would no longer be available to provide coverage upon your return to covered employment.

1. **USERRA Procedures**. The following procedures are to be followed for a Participant who is a military reservist once called to active duty:

   a. Upon notification that a Participant has been called to active duty, a Participant's hours will be frozen from the first day of the month following the date the employee begins active duty. Exception: If the Participant begins active duty on the first of any month, the Participant's hours will be frozen as of the first of that month.

b. The Plan Office will notify the Participant of the option to elect continuation of Medical, Dental, Disability, AD&D, life and vision coverage by self-paying the premium to the Plan Office. Coverage may be continued for a period that is the lesser of 18 months, or a period that ends on the day the individual fails to apply for or return to a position as an active Participant of the Plan.

c. Participants must notify the Plan Office of their return from active duty. The Plan Office will restore the Participant's frozen hours, and the Participant will once again be eligible for all benefits that he/she would normally have been eligible for had he/she not been called to active duty.

2. USERRA Return to civilian Employment. To qualify for re-employment rights under USERRA, including continued health benefits, your leave must be for the purpose of entering a "uniformed service", which includes the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard (full time duty), Commissioned Corps of Public Health Service and anyone else designated as Covered by the President of the United States during time of war or National Emergency. In addition, you must return to your same Employer or Another Employer that contributes to the Plan, within a specified period of time, depending upon the length of time you are absent for military service, as follows:

- If your **service lasts less than 31 days**, you must be available for covered employment on the next calendar day (so long as you had at least 8 hours rest after returning home by normal transportation) following the end of your service. 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 your service lasts for **31 days or more but less than 181 days**, you must be available for covered employment no later than 14 days after the end of your service. 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 your service lasts for **more than 180 days**, you must be available for covered employment, and continuation coverage will end, no later than 90 days following the end of your service.

3. Continuation of Coverage. If you are absent from covered employment as a result of military service for **less than 31 days,** you may elect to continue your coverage at no expense, for the first month. If you are absent from covered employment as a result of military service for **31 days or more**, you (and your eligible dependents) may elect to purchase COBRA-like coverage for up to 24 months (the first month of which is free). Please file a timely application following the end of the initial 30-day period of military service, make monthly self-payments directly to the Plan office, and notify the Plan office and your employer that you are leaving work for military service.

Typical rights under COBRA are for 18 months, rather than the longer 24-month period. USERRA continuation coverage is similar but not identical to COBRA requirements. Any continuation coverage taken pursuant to USERRA will be counted concurrently with your maximum COBRA continuation coverage period. Continuation coverage under USERRA will not terminate if you or your dependents become covered by another group health plan.

However, you may elect to waive your rights under federal law. In that case, your Reserve Account may be applied to provide coverage for your dependents at the applicable rate for active members.

The months of coverage so applied would no longer be available to provide coverage upon your return to covered employment.

DUTY TO NOTIFY PLAN 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 dependents must inform the Plan Office within 60 days of a divorce, legal separation or loss of dependent status. The Plan office will notify you of loss of coverage due to a reduction in hours or the expiration of extended coverage under the Plan's self-pay program, and your employer will provide notice for other Qualifying Events (ex. employee's death, termination of employment, reduction in hours, or Medicare becoming the employee's primary coverage). However, you are encouraged to inform the Plan Office of any Qualifying Event to best ensure prompt handling of your COBRA rights.

C. Family and Medical Leave Act. If your Employer has at least 50 Employees, your Employer may be required to continue to pay for your health coverage on the same terms as if you had continued work, during any approved leave under the Federal Family and Medical Leave Act of 1993 (FMLA). The plan will subsidize this payment. In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year (and continuation of health coverage) if:

(1) You worked for the Employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and

(2) You require leave for one of the following reasons:

(i) Birth of a child and to care for the newborn child within one year of birth;
(ii) Placement of a child for adoption of foster care and to care for the newly placed child within one year of placement;
(iii) Care for your child, spouse or parent with a serious medical condition;
(iv) Your own serious health condition that makes you unable to perform the essential functions of your job;
(v) Military Caregiver Leave (up to twenty-six (26) weeks during a 12-month period). Care for your spouse, son, daughter, parent, or next of kin who is a member of the Armed Forces (including the National Guard or Reserves), and undergoing medical treatment, recuperation, or therapy for a serious injury or illness; or
(vi) Any other purpose provided for by the FMLA.

Coverage will not be continued beyond the earlier of:

- Date contributions are not timely made;
- Date your Employer determines your approved FMLA leave is terminated; or
- Date your coverage involved discontinues as to your eligible class.

Details concerning FMLA leave are available from your Employer. If your Employer grants you an approved FMLA leave in accordance with FMLA, you may continue health coverage for you and your eligible dependents provided your Employer maintains the required contributions to the Plan on your behalf or you make any required contributions to the Plan. Requests for FMLA leave must be directed to your Employer. The Plan Office cannot determine whether or not you qualify. 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 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 ensure 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 Plan will not, however, pursue claims under the FMLA for participants or beneficiaries.

If your coverage terminates because your approved FMLA leave is deemed terminated by your Employer or you fail to return to work after exhausting your FMLA leave, you may, on the date of such termination, be eligible for COBRA continuation coverage under Federal law, on the same terms as though your employment terminated, other than for gross misconduct, on such date.

NOTE: 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.

It is the responsibility of your Employer (not the Plan) to notify you of your rights under FMLA and to approve your request for FMLA leave. It will be your responsibility to notify your Employer that FMLA leave is being taken.

D. 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 Plan'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 Plan 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.**

E. California Continuation Benefits Replacement Act (Cal-COBRA).

Under the California Continuation Benefits Replacement Act ("Cal-COBRA"), Small Employers with 2 to 19 employees are required to offer terminated Employees and their Dependents the opportunity to continue health insurance coverage. Cal-COBRA is the California program that is similar to Federal COBRA. If applicable, once you have exhausted Federal COBRA Continuation Coverage which generally lasts for up to 18 months, Cal-COBRA may extend continuation coverage for an additional 18 months, up to a combined total of 36 months. However, Employers with over 20 or more employees are subject to Federal COBRA. **Please contact Kaiser for Cal-COBRA eligibility questions.**

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

VI. KAISER PERMANENTE DEDUCTIBLE HMO PLAN

The Plan, through employer contributions, pays insurance premiums for health benefits available to you and your eligible dependent(s) through the Kaiser Permanente Deductible HMO Health Plan, a health maintenance organization ("HMO"). The Kaiser Permanente Deductible HMO Health plan benefits are briefly described below. Kaiser members must receive all covered care from providers at Kaiser Permanente Facilities and contracting facilities, except in emergency situations. Kaiser's medical care program provides access to services such as routine care with your own personal Plan physician, hospital care, laboratory, pharmacy services, and many other benefits described in the Kaiser Disclosure Form and Plan booklet. At most Kaiser Plan Facilities, you can usually receive all of the covered services you may need, including specialty care, pharmacy, and lab work.

Office visits and many of the services you receive at Kaiser are subject to a co-payment, which is due at the time of service.

You Must File an Enrollment Form

It is important that the Trust Fund Office have a completed enrollment form for you on file, since that is the basis against which the Plan verifies medical, vision and dental eligibility of you 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 Trust 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.*

A. PRINCIPAL BENEFITS FOR KAISER PERMANENTE TRADITIONAL PLAN.

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 Trust Fund delegates to Kaiser the discretionary authority to administer claims and determine eligibility for benefits.

The Services described below in subsection D. are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary

- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the services from Plan Providers inside our Northern California Region Service area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage (EOC)* for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services.

B. DEDUCTIBLE, COPAYMENTS, & COINSURANCE REIMBURSEMENT (through WageWorks).

Effective October 1, 2017, the Plan has contracted with WageWorks to provide reimbursement charges incurred for the Kaiser deductible and coinsurance charges incurred in 2017 and going forward. **Effective April 1, 2018, copayments were added to this program. (Note: For those charges incurred prior to Jan. 1, 2017 which have not been submitted along with a copy of the Kaiser billing, summary of account or explanation of benefits showing your responsibility for the Kaiser deductible and/or coinsurance and proof of payment to the Plan Office by March 31, 2018 will not be reimbursed.)** You and your family will no longer have to worry about the out-of-pocket deductible, copayment, and coinsurance expenses when you visit a Kaiser Permanente facility. The Plan's current deductible for self-only coverage is $1,500 and $3,000 for family coverage, and coinsurance is 20% up to $1,500 for self-only coverage and $3,000 for family coverage. This means that your WageWorks flex card will cover you and your family for up to $3,000 for self-only coverage and $6,000 for family coverage for all medical services including co-payments, deductibles and coinsurance except for prescription drugs. Below is a summary of how to use the WageWorks flex card:

- **Getting care-** Participants and/or dependents use one card for deductible and all medical co-payments and coinsurance. However, participants and/or dependents are still responsible for copayments relating to prescription drugs.
- **After the Visit-** All transactions will be processed on the card without having to submit a paper claim.
  Participants and/or dependents will not have to pay out of pocket for covered services.
- **Payments -** WageWorks will issue payments for deductibles, copayments and coinsurance (except prescription drugs) directly to Kaiser once the card is used. In the event that a service does not qualify for reimbursement, depending upon your account balance those services may be eligible for reimbursement under your VEBA Supplemental Accumulated Share (SAS) Account.

Once the participant and/or dependent has used up the total $3,000 for self-only coverage or $6,000 for family coverage on their flex card, any additional monies owed to Kaiser will be reimbursable through the VEBA Supplemental Accumulated Share (SAS) account if funds are available. **NOTE: There is a separate summary plan description for the Solano-Napa Counties Electrical Workers VEBA Reimbursement Medical Account Plan. To obtain a copy of this separate booklet please contact the Trust Fund office. There are certain eligibility rules pertaining to the VEBA Supplemental Accumulated Share Account (SAS) for certain employees while active and the use of the VEBA Accumulated Share (AS) account (for certain retired participants). Also, if you become disabled before retirement you may use your AS or SAS account for any eligible Internal Revenue Code medical expense. To be eligible for the VEBA, contributions must be made on your behalf either under a collective bargaining agreement between IBEW-NECA or pursuant to a participation agreement covering employees of IBEW Local 180 or Employees of the Solano-Napa Counties Electrical Workers JATC.**

EXAMPLE:

Member goes to Kaiser for 1- 5 office visits.	**$1,500 deductible is met and charged to the card.**
Member then goes for 6th office visit	**$20 copayment is charged to the card.**
Member then goes for 7th office visits	**and $20 copayment is charged to the card**
Member then gets an x-ray and MRI on the 8th office visit	**$10 copayment for x-ray and $50 copayment for MRI is charged to the card.**
On the 9th visit has hospital stay.	**$1,400 coinsurance is charged to the card (based on hospital stay 20% owed up to $1,500).**

This totals $3,000. Kaiser then bills for $100 which is reimbursed through the VEBA, if Funds are available in your personal VEBA Account.

C. SUMMARY OF KAISER BENEFITS.

For services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the co-payments and co-insurance, you pay for those Services add up to one of the following amounts:

Out of Pocket Maximum

Actives and Early Retirees

For self-only enrollment (a Family of one Member)	**$3,000** per calendar year
For an entire Family of two or more Members	**$6,000** per calendar year

Retirees

For any one Member	**$1,500** per calendar year

1. **Deductible $1,500 Individual/ $3,000 Family (None for Retiree Senior Advantage)**
   Deductible does not apply to preventive services/immunizations, covered health education programs, home health care, hospice service, prescription drugs, durable medical equipment, covered infertility treatment, and children's eye exam.

2. **Lifetime Maximum NONE**

3. **Professional Services (Plan Provider office visits)**

	You Pay (Actives & Early Retirees)	**Retiree (Senior Advantage)**
Most primary and specialty care consultations, exams & treatment	$20 per visit	$10 per visit
Routine physical maintenance exams, including well-woman exams	No Charge	No Charge
Well-child preventive exams (through age 23 months)	No Charge	
Family planning counseling	No Charge	
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No Charge	
Eye exams	No Charge	$10 per visit
Urgent care consultations, exams and treatment	$20 per visit	$10 per visit
Physical, occupational, and speech therapy	$20 per visit	$10 per visit

4. **Outpatient Services** **You Pay** **Retiree**

Outpatient surgery and certain other outpatient procedures	20% coinsurance	$10 per procedure
Allergy injections (including allergy serum)	No Charge	$3 per visit
Most immunizations (including the vaccine)	No Charge	No Charge
Most X-rays and laboratory tests	$10 per encounter	No Charge
Health education:		
Covered individual health education counseling	No Charge	
Covered health education programs	No Charge	

5. **Hospitalization Services**	**You Pay**	**Retiree**
Room and board, surgery, anesthesia, X-rays, laboratory tests & drugs	20% coinsurance	No Charge

6. **Emergency Health Coverage**	**You Pay**	**Retiree**
Emergency Department visits	20% coinsurance	$50 per visit

Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).

7. **Ambulance Service**	**You Pay**	**Retiree**
Ambulance Services	$150 per trip	No Charge

8. **Prescription Drug Coverage**	**You Pay**	**Retiree**
Most covered outpatient items in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service	Generic Retail ($10) Generic Mail ($20) Preferred Brand Retail ($30) Preferred Brand Mail ($60) Specialty ($30) (Up to 30-day supply for retail (up to 100-day supply) and up to 100-day supply for mail)	Generic ($10) Brand ($15)

9. **Mental Health Services**	**You Pay**	**Retiree**
Inpatient psychiatric hospitalization	20% coinsurance	No charge
Individual outpatient mental health evaluation and treatment	$20 per visit	$10 per visit
Group outpatient mental health treatment	$10 per visit	$5 per visit

10. **Substance Use Disorder Services**	**You Pay**	**Retiree**
Inpatient detoxification	20% coinsurance	No charge
Individual outpatient substance use disorder evaluation	$20 per visit	$10 per visit
Group outpatient substance use disorder treatment	$10 per visit	$5 per visit

11. **Home Health Services**	**You Pay**	**Retiree**
Home health care (up to 100 visits per calendar year)	No charge	No charge

12. **Other**	**You Pay**	**Retiree**
Eyewear purchased at Plan Medical Offices or plan optical sales Offices every 24 months	Amount in excess of $175 allowance	
Skilled nursing facility care (up to 100 days per benefit period)	20% coinsurance	No charge
Covered external prosthetic devices, orthotic devices	No charge	No charge
Covered services for infertility treatment and diagnosis	50% coinsurance	
Hospice care	No charge	No charge

This is a summary of the most frequently asked about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. **For details on your benefit coverage, please refer to Kaiser Permanente's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Kaiser Plan and its participants. To retain a copy please contact the Trust Fund Office.**

VIII. VISION CARE BENEFITS

The Plan provides coverage of insured vision care benefits through the Vision Service Plan ("VSP") for each eligible Participant and Dependent for a regular examination and lenses and frames when necessary for proper visual function or correction. Please refer to your VSP Evidence of coverage booklet for more details including exclusions and limitations. To obtain services of a Doctor, an eligible Participant and/or Dependent is required to contact a VSP participating doctor to make an appointment. Make sure you identify yourself as a VSP member. The doctor's office will verify eligibility and benefits. If you need to locate a VSP participating doctor, please call VSP at 1-800-877-7195 or find one at www.vsp.com.

VSP will pay the doctor directly. Except as otherwise provided in this section, you are responsible for the applicable co-payment and any additional costs for items only partially covered or not covered. If you use a doctor from the VSP network, this assures direct payment to the doctor and guarantees quality and cost control. However, if you decide to use the services of a doctor who is not a VSP participating doctor, you should pay the doctor his or her fee.

The Vision Service Plan (VSP) covers each eligible Participant and Dependent for a regular examination and lenses and frames when necessary for proper visual function or correction.

A. To obtain services. To obtain services of a Panel Doctor, an eligible Participant and/or Dependent is requested to contact a VSP participating doctor to make an appointment. Make sure you identify yourself as a VSP member; give your Social Security Number and the group name. The doctor's office will verify eligibility and benefits. If you need to locate a VSP participating doctor, call VSP at (800) 877-7195, or find one at www.vsp.com.

VSP will pay the doctor directly. Except as otherwise provided in this section, you are responsible only for the applicable co-payment **and any additional costs for items only partially covered or not covered. No co-payment applies for contacts**.

If you use a doctor from the VSP network, this assures direct payment to the doctor and guarantees quality and cost control; however, if you decide to use the services of a doctor who is not a VSP Panel Member, you should pay the doctor his or her fee. You will later be reimbursed in accordance with the VSP reimbursement schedule by VSP.

B. Services and Materials (Obtained with VSP Network Providers).

a. **Vision Exam** – Comprehensive examination of an eligible participant and dependent's visual function, once every 12-month period.

b. **Necessary Lenses and Frames** – If the vision examination indicates that new lenses or frames or both are necessary for the proper visual health of an eligible participant or dependent, lenses is available once every 12 months and Frames is available once every 24 months.

The below cost-sharing amounts may change at any time. Please call the Trust Fund Office or VSP for additional information.

EXAM SERVICES		
Comprehensive Well Vision Exam	$10 copay then covered in full	
Material	$25 copay	
LENSES		
Glass Plastic Single Lenses Lined Bifocal Lined Trifocal Lenticular	Covered in Full	
ENHANCED LENSES	Single Vision	Multifocal
Anti-Reflective Coating	$41	$41
Polycarbonate	$31	$35
Progressive	N/A	$55
Photochronic	$70	$82
Scratch-Resistant Coating	$17	$17
ALLOWANCES		
Frames	Up to $150 (20% discount off frame coverage)	
Other Locations	Up to $80 (Costco)	
Contact Lenses	Up to $130 in lieu of frames	

C. SAFETY GLASSES ENHANCEMENT TO VISION CARE BENEFITS.

Safety Glasses (called ProTec Rx) are available through the Plan to participants only. **The office co-payment is $10. Glasses co-payment is $25. There is an allowance of $150 for Frames.** Please refer to your Vision Service Plan ("VSP") Evidence of coverage booklet for more details including exclusions and limitations. To obtain services of a Doctor, an eligible Participant is required to contact a VSP participating doctor to make an appointment. Make sure you identify yourself as a VSP member. The doctor's office will verify eligibility and benefits. If you need to locate a VSP participating doctor, please call VSP at 1-800-877-7195 or find one at www.vsp.com.

D. VSP Grievance Procedures. If a Participant has a complaint/grievance (hereafter 'grievance') regarding VSP service or claim payment, the Participant may communicate the grievance to VSP by using the form which is available by calling VSP Customer Service Department's toll-free number (800) 877-7195 Monday through Friday 6:00 a.m. to 6:00 p.m. Pacific Standard Time. Grievances may be filed in writing within 180 days with VSP at 3333 Quality Drive, Rancho Cordova, CA 95670.

If you are dissatisfied with the results after exhausting VSP's grievance procedures, you may file a written appeal with the Plan's Board of Trustees, as provided in the Claims and Appeals Procedures described in section B, page 82.

The California Department of Managed Health Care ("Department") is responsible for regulating health care service plans and receiving complaints regarding VSP (and similar programs). If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by VSP, you may call the Department's help center toll-free at 888-466-2219. The hearing and speech impaired may use the California Relay Service's toll-free telephone number 1-877-688-9891 (TDD) to contact the Department.

Plan complaint forms and instructions are available online at the Department's website, http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_complaint.aspx.
NOTE: VSP'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. ***For details on your benefit coverage, please refer to Vision Service Plan's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Vision Plan and its participants.***

VIII. DENTAL BENEFITS

The Plan provides coverage for dental examinations and treatments performed by a licensed dentist or dental hygienist under the supervision of a dentist. Dental and orthodontic benefits are available to eligible participants and their dependents. The Plan currently provides dental care through an insured arrangement with United Health Care ("UHC") PPO Dental Plan. A separate booklet is available through UHC which describes this coverage. (Note: The Plan switched from a self-funded dental plan effective April 1, 2016).

A. USUAL, CUSTOMARY, AND REASONABLE CHARGES.

Usual, Customary and Reasonable ("UCR") charges are defined by the Plan as charges made by a dentist for eligible 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 same geographic area in which the charge is incurred for dental care comparable in severity and nature to the dental condition treated or being treated. Additionally, a specific fee to a specific Participant/Dependent is reasonable if it is justifiable considering special circumstances, or extraordinary difficulty of the case in question.

B. COVERED DENTAL SERVICES.

Below is a summary of your dental benefits. For complete details on your dental benefit coverage, please refer to UHC PPO Dental Plan's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Dental Plan and its Participants. Using a PPO provider will result and cost savings for yourself and the Plan. Additionally, using a PPO provider will also reduce the usage off your annual maximum providing a better opportunity for the maximum multiplier rollover benefit. Using a Non-PPO provider may result in a higher out of pocket cost for yourself due to allowable charges being paid at the usual customary & reasonable allowance ("UCR"). Any charges that exceed the UCR becomes the patient's responsibility.

Services	UHC PPO Dentists (Plan pays)	Non-UHC PPO Dentists (Plan pays)
Diagnostic Procedures (visits and consultations, prophylaxis/cleaning two in a calendar year)	100% of contracted rate	100% of Usual Customary & Reasonable Allowance ("UCR")
Basic Services (filings, simple tooth extractions, sealants)	90% of contracted rate	90% of UCR

Oral Surgery (extractions and other dental surgery including pre and post-operative care)	90% of contracted rate	90% of UCR
Preventative Care	100% of contracted rate	90% of UCR
All Major Services (crowns, inlays, on lays, and cast restorations)	90% of contracted rate	90% of UCR
Endodontics (pulpal therapy and root canal filling)	90% of contracted rate	90% of UCR
Periodontics (procedures necessary for treatment of diseases of the gum and bones supporting the teeth)	90% of contracted rate	90% of UCR
Prosthodontics (bridges, dentures, and 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 bridge work and crowns or removable partial and full dentures.	60% of contracted rate	60% of UCR
Orthodontics (procedures using appliances or surgery to straighten or realign teeth which would otherwise not function properly)	90% of contracted rate	90% of UCR
Deductibles	$25 per person/$75 per family each calendar year	
Dental Maximums **Consumer Maximum Multiplier Rollover***	$2,500 per eligible person/calendar year up to $700 **Note:** *If your original annual maximum is $2,500 and the total dental claims paid for you in one year is less than this: $1,250 then you qualify for an annual account award of: $600. Also, if all your claims for the year are in network you could also earn an annual network bonus of $100. Therefore, the potential consumer maximum multiplier earning for the year added to the next year annual maximum is up to: $700 and your following year annual maximum benefit would be $2,500 + $700 = $3,200.*	
Orthodontic Maximums **Child(ren)** **Adult**	 $2,500 Lifetime Maximum $3,000 Lifetime Maximum	
Waiting Periods	None.	

***In order to qualify for the maximum multiplier rollover benefit you must:**

1. **Visit your dentist at least once during the benefit year.**
2. **At the end of the benefit year, if the dollar amount is less than $1,250 in paid dental claims for you, you earn an annual account award.**

Services	Frequencies
Cleanings	Twice per calendar year
Complete Mouth X-Rays	Every 3 years
Bite wing X-Rays	Once in any 6-month period
Periodontal Surgery	One time every 3 years
Periodontal Maintenance	Twice per year
Dentures	Full set every 5 years
Replacements & Implants	Every 5 years
Dentures & Crowns	1 Per tooth every 5 years

C. HOW TO USE THE DENTAL PLAN.

During your first appointment, provide the dentist with your UHC Dental PPO Identification card which identifies you as participating in the UHC Dental PPO Plan. **Before treatment is started, be sure to discuss with the dentist the total amount of his or her fee and the portion that will be your responsibility. Have your dentist submit the Dental Claim Form to UHC Dental PPO.**

IMPORTANT: 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.

D. PREAUTHORIZATION OF DENTAL SERVICES- RECOMMENDED.

Preauthorization of benefits is not a requirement under the Plan. However, to learn about your Plan benefits in advance, or any time your dentist recommends more than $500 in dental work, you may want to have your dentist submit a preauthorization of benefits. This will enable you to budget any charges that are in excess of those covered by the Plan. Please be aware that even though your benefits are "preauthorized", you must also remain eligible for coverage. UHC Dental will notify your dentist of the Plan's UCR allowance for the procedures and whether there are any alternative treatments available.

E. DENTAL SERVICES NOT COVERED.

No payment will be made under this Plan for expenses incurred for any of the services listed below. **Please also refer to the evidence of coverage booklet from UHC Dental PPO for more exclusions and limitations**.

1. Crowns, Jackets and Gold or Cast restoration replaced prior to five (5) years having elapsed;
2. Prosthodontics appliances, including fixed bridges, partial dentures or complete dentures,
3. 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;
4. Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to: equilibration and periodontal splinting;
5. Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons;
6. Prescribed drugs, pre-medication or analgesia;

7. Experimental procedures;
8. All hospital costs and any additional fees charged by the Dentist for hospital treatment;
9. Charges for anesthesia, other than general anesthesia administered by a licensed Dentist in connection with covered oral surgery services;
10. Extra oral grafts (grafting of tissues from outside the mouth to oral tissues);
11. Services with respect to any disturbance of the temporomandibular joint (jaw joint);
12. Charges in excess of those determined to be Reasonable Charges;
13. Conditions caused by or arising out of an act of war, armed invasion or aggression; and
14. A condition for which the eligible individual is not under the care of a dentist.

IX. LIFE INSURANCE ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT (Active Participants Only)

A. LIFE INSURANCE BENEFITS.

The Solano-Napa Counties Electrical Workers Health and Welfare Plan has established an agreement with the UHC and Standard Insurance Company **to provide active participants only with life insurance benefits**. **Please note RETIREES and DEPENDENTS are not eligible for this benefit.** In the event of an active participants death for any cause, life insurance benefits in the amount of $5,000 is payable to the beneficiary named by you on your enrollment form. A separate Evidence of Coverage booklet is available at the Plan office which describes this coverage. ***For details on your benefit coverage, please refer to the Insurance Company's Evidence of Coverage Booklet available through the Trust Fund Office. The Evidence of Coverage Booklet is the binding document between the Life Insurance Plan and its participants.***

B. ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS (AD&D).

The Plan provides Accidental Death and Dismemberment benefits through UHC for its active participants only. A separate Evidence of Coverage booklet is available at the Plan office which describes this coverage. ***For details on your benefit coverage, please refer to the Insurance Company's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the AD&D Plan and its participants.***

The following AD&D benefits are payable to your beneficiary (for your loss of life) or to you for any other loss. 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.

1. $2,500 or $5,000 will be paid if you are an active Participant and as a result of an occupational or non-occupational accident, you suffer a loss of:

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

2. $5,000 will be paid to your beneficiary for your loss of life as a result of an occupational or non-occupational accident.

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

The AD&D benefit does not cover loss caused by: war or any act of war (whether or not declared); disease or infection (except infection of an accidental wound); suicide, intentional self-inflicted injury, or attempt at suicide while sane or insane, or under certain circumstances described in the booklet from the Insurance Company.

C. 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.

D. 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 Life and Accidental Death and Dismemberment benefits, the designation of beneficiaries, disability premium waivers and conversion privileges are explained in detail in the booklet from the Insurance Company. Please contact the Trust Fund Office for a copy and/or details.

X. FEDERAL NOTICES

A. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996.

Pursuant to the Newborns' and Mothers' Health Protection Act of 1996, insurers and group health plans may not restrict benefits for any hospital length of stay for the mother or newborn child to less than 48 hours following normal delivery or less than 96 hours following a cesarean section delivery.

In accordance with Federal Law, plans and insurers may not require that a provider obtain preauthorization from the plan or insurer for prescribing either of the foregoing lengths of stay. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours or 96 hours as applicable. Also, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). Furthermore, plans and insurers may not set levels of benefit or out-of-pocket costs so that any portion of the 48-hour (or 96 hour as applicable) stay is treated in a manner that is less favorable to the mother or newborn than any earlier portion of the stay.

B. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998.

Your Plan, as required by the Women's Health and Cancer Rights Act of 1998 ("WHCRA") covers medical and surgical benefits for mastectomies for eligible participants and dependents receiving benefits under the

Plan through one of the Plan's medical carriers. This coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All states of reconstruction of the breast on which the mastectomy was performed (including coverage for nipple and areola reconstruction, nipple and areola repigmentation to restore the physical appearance of the breast, as a required stage of reconstruction);

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

3. Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

The coverage is subject to the Plan's annual deductibles and coinsurance provisions. For more information please call either Kaiser at 800-464-4000, if you are enrolled under the Kaiser HMO plan) or the Plan Office.

C. PRIVACY OF PROTECTED HEALTH INFORMATION (PHI) UNDER HIPAA.

This Plan and any Business Associate will use and disclose protected health information ("PHI") in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations.

PHI is defined as individually identifiable health information that is maintained or transmitted by this Plan in any form or medium (oral, written, or electronic). Individually identifiable health information is health information, including demographic information, that is created or received by a health care provider, employer, health care clearinghouse or this Plan and relates to the past, present or future physical or mental health condition of you and/or your eligible dependents, including payment information for the provision of health care. When held by this Plan, it also means information that either identifies you and/or your eligible dependents directly or indirectly, in that one has a reasonable belief that you or your eligible dependents can be identified using the information. For example, your name, address, birth date, marital status, Social Security Number, and choice of health plan would be considered PHI. Other examples are the amount of contributions paid by your employer for your coverage, or whether you are an active employee, retiree, or Medicare enrollee.

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

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

2. Required Uses and Disclosures of PHI: This Plan must disclose PHI to you upon request to access your own PHI, with limited exceptions, or to request an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of U.S. Department of Health and Human Services ("HHS") and its Office of Civil Rights ("OCR") or other authorized government organizations to investigate or determine this Plan's compliance with the Privacy Rule or when required by a court order. Use and disclosure of PHI may also be required when the Plan believes in good faith that such disclosure is necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.

3. Agreed to Uses and Disclosures of PHI by You After an Opportunity to Agree or Disagree to the Disclosure: This Plan will disclose PHI to family members, other relatives or close personal friends if the information is directly relevant to the family or friend's involvement with your health care or payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected. However, PHI of persons who are deceased for more than fifty (50) years is not protected under the HIPAA privacy and security rules.

4. Allowed Uses and Disclosures of PHI For Which Authorization or Opportunity to Object is Not Required: This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, worker's compensation programs and correctional facilities.

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

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

These uses and disclosures are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices For Protected Health Information. Additional copies of these documents may be obtained from the Plan Office.

5. Your Individual Rights: HIPAA and the Privacy Rule afford you the following rights:

- **Right to Request Restrictions.** You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a request. If this Plan agrees, it is bound by the restriction except when otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction. If you wish to make a request for restrictions, please make your request in writing to the Plan's Privacy Officer at the address noted below.

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

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

- **Right to Amend your PHI.** You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a request form to amend PHI in a Designated Record Set. This Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

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

- **Right to Notice in Event of Breach.** You have the right to receive and the Plan is required to provide a Notice to you, as soon as reasonably possible, but no later than 60 days after discovery of a breach of your unsecured PHI. There will be a presumption that any unauthorized acquisition, access, use, or disclosure of your PHI, in violation of the Privacy rule is a breach, *unless* the Plan demonstrates that there is a low probability that your PHI has been compromised based on the results of a risk assessment or an exception permitted by the Privacy Rule applies. This Plan has implemented a policy to require the performance of a risk assessment in all cases of impermissible uses or disclosures of PHI to ensure your PHI will not be compromised and intends on complying with any future guidance on risk assessments.

- **Right to Restrict Disclosure of Health Information if Paying Out-of-Pocket.** If you fully paid for services out-of-pocket and you request that the Health Care Provider not disclose your PHI related to those services to the Plan, the Health Care Provider must accommodate your request, except where the Health Care Provider is required by law to make a disclosure.

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

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

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

7. This Plan's Duties: In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The Plan Office has designated this group of employees to include Mail Clerks, Eligibility Certifiers, Supervisors and Managers. The employees described above may only have access to and use and disclose PHI for plan administration functions. A mechanism shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

This Plan and if applicable, the Insurer (ex., Kaiser) is required by law to provide you with its Notice of Privacy Practices ("Notice") upon request at any time. The privacy practices for coverage through Kaiser are subject to its own notice. You can view Kaiser's own Notice at www.kaiserpermanente.org. The Notice must be distributed by this Plan to new employees and dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

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

8. <u>Authorization to Use or Disclosure Your PHI</u>: Except as provided for in this section or as permitted by law, the Plan will not release your PHI without your written authorization. Even in situations in which release of PHI may be permitted as described above, the Plan may request your written authorization to release information to the Board of Trustees or others. The Plan Administrator's office has an Authorization Form that you may sign to authorize release of all or part of your PHI. The following uses and disclosures will be made only with your written authorization subject to your right to revoke, amend, or limit your authorization in writing, at any time:

- **Marketing Authorization.** This Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages it use or purchase. (However, this Plan may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided under the plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.)
- **Psychotherapy Notes**. Psychotherapy notes are separately filed notes about your conversations with your mental health professional. Although this Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you.
- **Sale of PHI.** The Plan is prohibited from directly or indirectly receives financial or non-financial remuneration in cash or in kind (including granting license rights) from a third party in exchange for your PHI unless permitted under HIPAA or with your prior written authorization. This Plan does not sell nor does it intend on selling your PHI.

- **Fundraising Purposes.** Except as permitted under HIPAA or with your prior written authorization, the Plan cannot use or disclose your PHI for fundraising purposes. You have the right to opt out of receiving any fundraising communications whether received in writing or over the phone. This Plan does not use nor does it intend to use your PHI for fundraising purposes.
- **Genetic Information.** Your PHI includes genetic information. Although this Plan does not routinely obtain genetic information, in regard to underwriting, premium rating, or similar activities, the Plan will not use or disclose genetic information about an individual, as prohibited under the Genetic Information Nondiscrimination Act of 2008.
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- **Child Immunization Proof to Schools.** The Plan may disclose proof of immunization of a student to the school prior to admitting the student, where State or other law requires such information, upon obtaining the consent of the parent, guardian or student of consenting age.
- **Other Uses of Health information.** Other uses and disclosures of health information not covered by this Notice or the laws that apply to the Plan will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

9. <u>Duties of the Board of Trustees With Respect to PHI</u>: This Plan will may disclose PHI to the Board of Trustees for Plan administration purposes. This may include information pertaining to claims and appeals, including a review of a subrogation claim, or Participant inquiries in limited circumstances, or summary health information so that the Board may solicit premium bids from health insurers or similar entities. The Trustees have amended this Plan's Trust Agreement and signed a certification agreeing not to use or disclose your PHI other than as permitted by the plan documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement, Notice of

Privacy Practices For Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Plan Office.

10. Right to File Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Plan Office or with the Secretary of the U.S. Department of Health and Human Services. If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer at:

Solano-Napa Counties Electrical Workers Health and Welfare Plan
c/o BeneSys Administrators
P.O. Box 1306
San Ramon, CA 94583
Phone: (925) 208-9980

A complaint may also be filed with the U.S. Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. All complaints must be in writing and filed within 180 days of the date you knew or should have known of the violation. This time limit can be waived if good cause is shown. This Plan will not retaliate against you for filing a complaint.

11. Security Standards Under HIPAA: The Board of Trustees will implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of electronic protected health information that the Fund creates, receives, maintains, or transmits on behalf of the Plan pursuant to 45 C.F.R. Section 164.504(f)(1)(ii), enrollment or disenrollment information disclosed pursuant to 45 C.F.R. Section 164.504(f)(1)(iii), or information disclosed pursuant to an authorization under 45 C.F.R. Section 164.508. In implementing such safeguards, the Trustees will:

(1) Ensure that the Adequate Separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;

(2) The Trustees will ensure that any agent, including a sub-contractor, to whom it provides electronic protected health information, agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the information that it creates, receives, maintains or transmits on the Plan's behalf; and

(3) The Trustees will report to the Plan any security incident of which it becomes aware.

D. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA).

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is a federal law that prevents large group health plans (such as this Plan) and health insurers (such as Kaiser) that provide mental health or substance abuse benefits from imposing less favorable benefit limitations, including financial requirements (e.g., deductibles, copayments, coinsurance and out of pocket limitations) and treatment limitations (e.g., number of visits or days of coverage) on those benefits than on medical and surgical benefits offered. As such, the limitations applicable to mental health or substance abuse benefits can be no more restrictive than the predominant limitations applied to substantially all medical and surgical benefits. Pursuant to the Final MHPAEA rules, the Plan or Health Insurer will provide any current participants or potential participants, or contracting providers, upon request, the criteria for medical necessity determinations with respect to mental health/substance abuse benefits and the reason for any denial of reimbursement or payment for services with respect to mental health/substance abuse benefits will also be provided upon request.

It is the intention of the Board of Trustees and the contracted insurers (Kaiser Permanente) that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more information on MHPAEA, please visit the Department of Labor website at *www.dol.gov/ebsa/mentalhealthparity/*.

E. PATIENT PROTECTION AND AFFORDABLE CARE ACT ("PPACA").

1. Non-Grandfathered Plan. The Board of Trustees believes this Plan is a "Non-Grandfathered health plan" under the federal law known as the Patient Protection and Affordable Care Act of 2010 ("ACA"). The Plan became a non-grandfathered Plan effective September 1, 2013. Being a Non-grandfathered health plan means that the Plan is required to include certain consumer protections of the ACA, for example, requiring the provision of preventive health services without any cost sharing and elimination of annual and lifetime limits on the Plan's Essential Health Benefits. (For a definition of what constitutes as Essential Health Benefits please visit ***www. Healthcare.gov/glossary/essential-health-benefits***).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Manager. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 1–866–444–3272 or ***www.dol.gov/ebsa/healthreform***. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

2. No Pre-Existing Condition Exclusions for Any Individual. The ACA prohibits insurance plans in the individual and group markets from imposing pre-existing condition exclusions on any individual for Plan Years beginning after January 1, 2014. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for an individual with cancer because the individual had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the individual because of the individual's pre-existing medical condition).

3. Dependent Child Coverage UP to Age 26. In accordance with the ACA, the Plan will permit a Participant's eligible Child(ren) to be enrolled and maintained as a Dependent through the end of the month in which the Child(ren) attains age 26, regardless of whether the Child(ren) are eligible for coverage through his or her own employer-sponsored group health plan (or his or her Spouse's plan) and regardless of the Child(ren)'s marital status, student status, financial dependency, residency, or employment status.

4. Minimum Essential Coverage. Under the ACA, Plan sponsors are required to provide minimum essential coverage. Minimum essential coverage includes jointly-sponsored coverage such as this Plan. The ACA also establishes a minimum value standard of benefits for health plans. Minimum value means coverage under a health plan (such as this Plan) meets the minimum value standard if the plan's share of the total allowed costs of benefits provided is 60% or greater. The Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.

5. Availability of Summary of Benefits & Coverage. The ACA requires group health plans and health insurers to provide a Summary of Benefits and Coverage, also known as the "SBC", to Participants and their Dependents. The SBC is a standard format, written in easy-to-understand language, summary of what the Plan covers and what it costs. It is intended to help you understand and compare the different benefits and coverage options available to you under the Plan. Under the ACA, you also have a right to request and receive within 7 business days a copy of the Plan's SBC in paper form, at any time and free of charge. If you want a copy of the Kaiser HMO Plan SBC, please call the Trust Fund Office.

6. Elimination of Lifetime and Annual Dollar Limits on Essential Health Benefits. The ACA prohibits both grandfathered and non-grandfathered health plans from imposing lifetime and annual dollar limits on Essential Health Benefits. In accordance with the requirements of the ACA, this Plan does not impose any lifetime and annual dollar limits on its Essential Health Benefits. However, the Plan is permitted to impose annual limits on certain non-Essential Health Benefits consistent with the ACA and lawful

regulations issued thereunder. Non-Essential Health Benefits means benefits that are not Essential Health Benefits as determined by the Plan and Claims Administrator in its sole discretion.

7. Preventive Services. The Plan through its insured arrangement with Kaiser will cover 100% of the cost of certain preventive services (including but not limited to office visits, immunizations and screenings) in accordance with the recommendations and guidelines set by the federal government pursuant to the ACA, as amended and when those services are provided by a network provider. This means that certain preventive services are not subject to any deductible or copayment, and you will not have to pay any cost-sharing. **Preventive services provided by out-of-network providers are not covered. In general, the Plan will cover all preventive services listed in the federal government's recommendations and guidelines (for the latest list of federal government's guidelines for preventive care see https://www.healthcare.gov/coverage/preventive-care-benefits/.**

8. Emergency Services. Under the ACA, if a Non-grandfathered plan provides benefits for emergency services it must cover emergency services without prior authorization and regardless of whether the provider is in-network or out-of-network, and any co-insurance or co-payment imposed on emergency services received out-of-network cannot exceed the amount imposed on emergency services received in-network. As a reminder, there is no requirement to pre-certify the use of a hospital-based emergency services performed by a non-network emergency room.

9. Choice of Provider. The Plan's HMO benefits offered through Kaiser recommends and allows the designation of a primary care provider and pediatrician. You have the right to designate any primary care provider and pediatrician for your child who participates in the network and who is available to accept you or your family members. If the Plan or health insurance coverage designates a primary care provider automatically, then until you make this designation, the Insurer will designate one for you. For information on how to select a primary care provider, and for a list of participating providers, please contact Kaiser.

You do not need prior authorization from this Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Kaiser HMO network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology in the Plan's HMO network, contact Kaiser.

10. Prohibition on Rescissions. Under the ACA, group health plans and insurers must not rescind coverage (meaning cancel or discontinue coverage retroactively) unless a covered individual commits fraud or makes an intentional misrepresentation of material fact. However, a retroactive cancellation or discontinuance of coverage is not a rescission if it: has only prospective effect; is initiated by the covered individual; due to delay in administrative record-keeping; termination of coverage retroactive to the divorce if a plan does not cover former spouses; or attributed to a failure to timely pay required premiums or contributions toward the cost of coverage. In accordance with the ACA, this Plan will not rescind coverage unless permitted by the ACA or your and/or your eligible dependent commits fraud or makes an intentional misrepresentation of material fact.

11. For More Health Care Reform Information. Under the ACA, this Plan is required, among other things, to include certain consumer protections, for example, requiring the provision of preventive health services without any cost sharing, elimination of annual and lifetime dollar limits on Essential Health Benefits, and extension of dependent coverage. Please visit the Department of Labor website at *www.dol.gov/ebsa/healthreform* for more information about the ACA's provisions.

XI. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A. RULES AND PROCEDURES FOR ADMINISTERING QMCSOS (including National Medical support Notice).

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 also recognize a properly completed National Medical Support Notice ("NMSN") that meets the requirements of the Employee Retirement Income Security Act ("ERISA").

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. The child, to be covered for benefits by this Plan, must meet Plan requirements for an eligible Dependent child including age requirements (under Age 26).

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.

B. QMCSO/NMSN REQUIREMENTS. 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; and

(3) In addition, for an order to be a QMCSO/NMSN it must clearly specify the following information:

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

(ii) 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; and

(iii) Period to which the QMCSO applies.

C. PROHIBITED PROVISIONS/ENROLLMENT REQUIREMENTS. The order will fail to be a QMCSO/NMSN 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. The Plan requires that the Participant and all of his eligible Dependents be enrolled under only one Health Plan option. Therefore, a Participant must select and enroll in a Health Plan option that would be available to the Participant, the child(ren) covered under the QMCSO and./or NMSN and to the Participant's other eligible Dependents. If a Participant enrolls in a Plan that would not be available to the child(ren) covered under the QMCSO and/or NMSN because they reside outside of the Plan's service area,

the Participant will be required to enroll in another Health Plan option that would cover the child(ren). The Plan will follow the requirements of the QMCSO and/or NMSN even if it requires that the Participant be forced to enroll in a different Plan option.

Please be aware that if a child covered under a QMCSO and/or NMSN was enrolled independent of the Participant neither the Participant nor any other Dependents would be considered enrolled in the Plan until such time as the Participant has completed all Enrollment Procedures. In addition, the Participant and any other eligible Dependents would then be limited to enrollment into only that Health Plan option that the child covered under the QMCSO and/or NMSN has been enrolled in.

D. PROCEDURE FOR HANDLING COURT ORDERS & DETERMING QMCSO/NMSN. 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. 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. 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. The steps that the Plan office will follow to establish and determine whether a court order would qualify as a QMCSO/NMSN are:

(i) The Participant must provide the Plan Office with a copy of the court order and/or QMCSO and/or NMSN.

(ii) Within a reasonable period after receipt of the QMCSO and/or NMSN, the Plan Office or the Plan's legal counsel will notify the Participant in writing if the court order and/or QMCSO and/or NMSN is acceptable to the Plan.

(iii) If the Plan determines that the court order and/or QMCSO and/or NMSN is not acceptable, or if additional information is required, the Participant will be notified in writing by the Plan or the Plan's legal counsel.

a. **If a QMCSO and/or NMSN is denied**. The notice will describe the reasons for denial. There is a right to appeal a denial. A summary of the Plan's appeal procedures will be included in the notice of denial. In most instances however, you will simply be asked to revise the order in such a way that it is a proper QMCSO and/or qualified NMSN.

b. **If additional information is required**. The notice will describe what is needed. There will be sixty (60) days to respond. If you do not respond within the sixty (60) days, the request for the QMCSO will be deemed canceled.

E. 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.

F. 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.

XII. CLAIMS AND APPEALS PROCEDURES

A. GENERAL RULES.

The Board of Trustees has established the claims and appeals procedures with the intent of complying with the regulations issued by the U.S. Department of Labor. The claims and appeals procedures set forth below apply only for non-insured benefits. The claims and appeals rules for insured benefits are governed by the rules (known as the Evidence of Coverage booklet) of the specific insurance companies and Health Maintenance Organizations (HMOs), which are available upon written request from the applicable insurance company or HMO (ex. **Kaiser, UHC Dental, VSP**). **These entities have their own claims review and appeals procedures, which are described in their materials and which you must follow.**

All benefits will be paid in accordance with the terms of the Plan. All claims for benefits payable under the Plan, shall be filed on forms provided by the Trust Fund office and **should be filed within 12 (twelve) months from the date the expense was incurred**. Failure to do so will result in non-payment. **It is your responsibility to ensure that your proofs of claims are timely filed with the Trust Fund office.**

B. CLAIMS PROCEDURE.

1. Notice of Adverse Benefit Determination. If your claim is denied either in whole or in part, you will be provided with a written notice of the decisions and the procedure for filing an appeal of an "Adverse Benefit Determination" (where urgent care is involved an initial notice may be provided verbally within 72 hours with written confirmation furnished within three days after). Any reference to 'you" in this section includes you and your Authorized Representative. An Authorized Representative is a person you authorize in writing to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

An "**Adverse Benefit Determination**" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) for a service, supply or benefit under the Plan. Each of the following is an example of an Adverse Benefit Determination:

(i) A payment of less than 100% of a Claim for benefits (including coinsurance or co-payment amounts of less than 100% and amounts applied to the deductible);
(ii) A denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;
(iii) A failure to cover an item or service because the Plan considers it to be Experimental, Investigational, not Medically Necessary;
(iv) A restriction on reimbursement for particular services because they are classified as related to a mental or nervous, rather than a physical, condition;
(v) A decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan;
(vi) Any rescission of coverage (meaning retroactive cancellation or discontinuance as described in Labor Reg. Section 2590.715-2712(a)(2)) of your benefits including disability benefits will be considered an adverse benefit determination that would trigger the Plan's appeals procedures. However, if the retroactive rescission was due to a failure to timely pay required premiums or contributions towards the cost of coverage that would not be considered an adverse benefit determination.

Notice of Initial Benefit Determination. **If all or part of your claim is denied, you will receive a written notice that explains:**

(i) The specific reason(s) for the denial, including references to specific Plan provision(s), as applicable, upon which the denial was based;
(ii) A description of any additional material or information necessary to perfect the Claim and an explanation of why the material or information is necessary;
(iii) The appeals procedures and the applicable time limits that apply to them and any external review process available;
(iv) Your right to bring a civil action under Section 502(a) of ERISA after an adverse benefit determination on appeal.
(v) Information sufficient to identify the claim involved, including the date of the service, the health care provider, and the claim amount (if applicable);
(vi) If applicable, a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, as soon as practicable (the Plan will not consider a request for such diagnosis or treatment information, in itself, to be a request for an internal appeal or an external review);
(vii) A description of the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793.
(viii) If the claim is denied on the basis of an internal rule, guideline, protocol, or other similar criterion, the notice will either state the specific rule, guideline, protocol, or other similar criterion; or include a statement that a copy will be provided free of charge upon request (if applicable).
(ix) If the claim is denied on the basis of a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request (if applicable).

Disability Claim Denial Initial Notice. Effective April 1, 2018, for **Denial of Disability claims,** in addition to the information set forth above, your denial notice will include the following:

(1) Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);Statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records and other information to your claim for benefits;
(2) Statement of your right to present evidence and testimony in support of your claim during the appeal/review process;
(3) Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;
(4) Statement that on appeal, you will have the right to respond to the denial if the Plan receives new or additional evidence and you will also be provided, free of charge, with any new or additional evidence considered, as soon as it becomes available to the Plan and sufficiently in advance of the date on which the appeal determination notice is required to be provided to you under the Plan's rules. (This will usually be before the next regularly scheduled meeting of the Board of Trustees unless special circumstances require a further extension of time); and
(5) If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

2. Claims. The term "Claim" means a request for a benefit made by a Participant or Dependent in accordance with the Plan's procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a Participant files a Claim for specific benefits and the Claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a Claim.

Claims are categorized as follows:

(i) Urgent Claim. The term "Urgent Claim" means a Claim for medical care or treatment that, if normal Pre-Service standards for rendering a decision were applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.
(ii) Pre-Service Claim. The term "Pre-Service Claim" means a Claim for a benefit for which the Plan requires precertification or prior authorization before medical care is obtained in order to receive the maximum benefits allowed under the Plan.
(iii) Concurrent Claim. The term "Concurrent Claim" means a Claim that is reconsidered after an initial approval has been made resulting in a reduction, termination or extension of the previously approved benefit.
(iv) Post-Service Claim. The term "Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Urgent or Concurrent Claim. This will generally be a claim for reimbursement for services already rendered.
(v) Disability Claims. The term "Disability Claim" means any Claim that requires a finding of Total Disability as a condition of eligibility.

3. Time Limits for Claims Procedure.

Claim Type	Plan Must Make Decision Within:
Urgent Claims	72 hours
Pre-Service Claims	15 days
Post-Service Claims	30 days
Disability Claims	45 days
Please see below for extensions and details.	

(i) Urgent Claims. You will be notified of a decision, whether adverse or not, as soon as possible, taking into account the medical exigencies, but not later than **72 hours** after the claim is received. If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, you will be notified as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. You will then be given a reasonable additional amount of time, but not less than 48 hours, to provide the information and you will be notified of the decision no later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

(ii) Pre-Service Claims. If the Plan requires you to obtain advance approval of a non-urgent service, supply, or procedure before a claim will be payable, such a request for prior approval is considered a Pre-Service Claim. You will be notified of the decision not later than **15 days** after receipt of the Pre-Service Claim. This time period may be extended up to an additional 15 days due to circumstances beyond the control of the Plan. If an extension is necessary, you will be notified of the extension before the end of the initial 15 or 30-day period. To illustrate, there may be an extension if you have not submitted sufficient information, in which case you will be notified of the information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the

claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

If a Pre-Service Claim is submitted, but which otherwise fails to follow the Plan's procedures for filing Pre-Service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed.

(iii) Concurrent Claims. If you received pre-authorization for an ongoing course of treatment that does not involve an Urgent Claim, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to the Plan and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care and you request an extension of the course of treatment that is in progress at least 24 hours prior to the expiration of the approved Urgent Claim, you will be notified within 24 hours after receipt of the request.

(iv) Post-Service Claims. You will be notified of the decision not later than **30 days** after receipt of the Post-Service Claim. This time period may be extended up to an additional 15 days due to circumstances beyond the control of the Plan. If an extension is necessary, you will be notified, before the end of the extension before the end of the initial 30-day period. You will have 45 days from receipt of the notice to supply the additional information and will be notified of the claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

C. APPEALS PROCEDURE.

1. Appealing an Adverse Benefit Determination. If your claim is denied in whole or in part, you or your authorized representative may appeal the denial to the Board of Trustees. You will have **180 days** from the date you receive your notice of an Adverse Benefit Determination to submit a written appeal of the determination to the Trust Fund office. Appeals of urgent claims may not be submitted via US Postal Service and all oral requests of such urgent claims appeals must be followed by a faxed written request within 24 hours.

You may submit written comments, documents, records, and other information relating to your claim in connection with your appeal, whether or not the comments, documents, or other information were submitted in connection with the initial claim. You may also request to receive, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to your claim for benefits. **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.**

2. Appeal Process. The review of your appeal will take into account (if applicable) all relevant comments, documents, records, and other information submitted by you that relate to your claim. In addition, the decision maker on appeal will be different from the decision maker at the initial claim level, as will any health care professional who is consulted at the appeal level.

In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Board of Trustees may consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted will not be the individual who was consulted in connection with the denial of the claim that is the subject of the appeal (nor the subordinate of such individual).

Upon request, the Board of Trustees will provide (if applicable) the identification of any medical or vocational experts whose advice was obtained on its behalf, as applicable, in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

You are also entitled to the following appeal rights:

- the comments, documents, records and other information you submit in support of your appeal may include evidence and written testimony;
- during the course of the determination of your appeal, you will be provided (free of charge) with any new or additional evidence considered, relied upon, or generated in connection with the claim, as well as any new or additional rationale for a denial at the appeals stage as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided and a reasonable opportunity for you to respond to such new evidence or rationale prior to that date; and
- your coverage will be continued pending the outcome of any mandatory level of appeal that is pursued (this means that benefits for an ongoing course of treatment (concurrent care) will not be reduced or terminated).

3. Time Limits for Processing Appeals.

For **urgent claims**, the determination will be sent within 72 hours of receipt of the appeal by the Trust Fund office.

For **pre-service claims**, the determination will be sent 30 days after receipt of the appeal.

For **post-service and disability claims**, a decision will be rendered by the Board of Trustees no later than the date of the first Board of Trustees meeting following the Plan's receipt of the request for review, unless the request for review is filed within 30 days prior to the date of such meeting. In such case, a benefit determination may be made no later than the second Board of Trustees meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be rendered no later than the third meeting of the Board of Trustees following the Plan's receipt of the request for review. The Trust Fund Office shall provide you with a written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Trust Fund Office will notify you of the Board of Trustees' determination of your request for review as soon as possible, but not later than 5 days after the benefit determination is made.

4. Notice of Appeal Determination. If the Board of Trustees determines that benefits should be paid, the Plan will take whatever action is necessary to pay them as soon as possible.

A **"Final Adverse Benefit Determination"** is an Adverse Benefit Determination that has been upheld by the Plan at completion of the Plan's Internal Appeals Procedures or an adverse benefit determination for which the internal appeals procedures have been exhausted under the "deemed exhaustion rules" (explained below). If your Appeal is denied, the Notice of Final Internal Adverse Benefit Determination will explain:

(i) The reason(s) for the denial, including references to specific Plan provisions, as applicable, upon which the denial was based;
(ii) Your entitlement to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to your claim for benefits; and
(iii) Your right to bring a civil action under section 502(a) of ERISA;
(iv) Information about your right to Independent External Review for certain types of claims (if applicable);

(v) If an internal rule, guideline, protocol, or other similar criterion was relied upon, the notice will state the specific rule, guideline, protocol, or other similar criterion; or include a statement that a copy of will be provided free of charge upon request; and

(vi) If the claim is denied based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan, as applicable, to the medical circumstances, or include a statement that such explanation will be provided free of charge upon request.

Appeal of Disability-Claim Notice. Effective April 1, 2018, for **Appeals of Disability Claims**, in addition to the information set forth above, your Appeal Denial Notice will include:

(1) Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;

(2) Any Plan imposed timeline for filing a lawsuit pursuant to your right under ERISA section 502(a) and the expiration date for bringing suit; and

(3) If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

5. Exhaustion of Internal Appeals Process. Generally, you are required to complete all claims and appeal procedures of the Plan before being able to bring a civil action. However, subject to an exception (explained below) if the Plan does not strictly adhere to all Internal Claims and Appeals requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") on the grounds that the Plan has failed to provide a reasonable Internal Claims and Appeals process that would result in a decision on the merits of the claim, and you may pursue any available remedies under ERISA Section 502(a) or under State law, as applicable. You may also initiate an External Review (discussed in the External Review Section below).

There is an Exception to the Deemed Exhaustion rule. The Internal Claims and Appeals process will not be deemed exhausted if:

- Violation was minor and is not likely to cause, prejudice or harm to you; and
- Violation was for good cause or due to matters beyond the Plan or its Designee's control; and
- Violation occurred in the context of an ongoing, good faith exchange between you and the Plan or its Designee.

This exception is not available if the violation is part of a pattern or practice of violations by the Plan or its Designee.

You may request a written explanation of the violation from the Plan or its Designee, and the Plan or its Designee must provide such explanation within ten (10) days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

If a court rejects your request for immediate review on the basis that the Plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within

a reasonable time after the court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

D. When Lawsuit May be Started.

No lawsuit may be filed (started) more than one year after services were provided or benefits partially or totally denied or after a denial after review by an Independent Review Organization (if applicable for Kaiser medical benefits), including any denial of a claim for disability benefits, or an otherwise adverse determination was made against you. The provisions of this Section shall apply to and include any and every claim for benefits from the Fund, any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, regardless of when the act or omission upon which the claim is based occurred, and regardless of whether the claimant is a "Participant" or "Beneficiary" of the Plan within the meaning of those terms as defined by ERISA. Such claim shall be limited to benefits due to him/her under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan and shall not include any claim or right to damages, either compensatory or punitive. Any legal action must be brought in the U.S. District Court for the Northern District of California.

Effective January 1, 2018, if the Plan has failed to comply with the claims and appeals procedure requirements for Disability claims, you will not be prohibited from filing suit or seeking court review of a disability claim denial based on a failure to exhaust the administrative remedies under the Plan unless the violation was the result of a minor error or considered "de minimis." This would mean: (a) non-prejudicial, (b) attributable to good cause or matters beyond the Plan's control, (c) in the context of an ongoing good-faith exchange of information, (d) and not reflective of a pattern or practice of non-compliance by the Plan.

E. EXTERNAL REVIEW.

Generally, you must exhaust your internal claims and appeals procedures before you may request external review unless the Plan has failed to comply with the claims and appeals procedures described above. **Kaiser has established an external review process to examine coverage and claims denials under certain circumstances. Because this Plan's medical benefits are insured through Kaiser, any External Review process needs to be filed with Kaiser's own Independent Medical Review Process. Below is just a brief summary, for complete details please refer to your Kaiser Evidence of Coverage booklet for more information on how to file an External Review with Kaiser.**

1. Independent Medical Review (California Department of Managed Health Care)- through KAISER

If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review ("IMR") process managed by the California Department of Managed Health Care (DMHC). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against Kaiser. You may qualify for IMR if all of the following are true:

- One of these situations applies to you:
  a) you have a recommendation from a provider requesting Medically Necessary Services
  b) you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
  c) you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition

- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary.
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission.

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials." (Please refer to the Kaiser evidence of coverage booklet for a definition of what is considered "experimental or investigational.)

If the DMHC determines that your case is eligible for IMR, it will ask Kaiser to send your case to the DMHC's IMR organization. The DMHC will promptly notify you of its decision after it receives the IMR organization's determination. If the decision is in your favor, Kaiser will contact you to arrange for the Service or payment.

XIII. GENERAL PROVISIONS

A. RIGHT OF RECOVERY AND SUBROGATION/ACTS OF THIRD PARTIES.

1. General Subrogation and Right of Reimbursement Rule. This Plan does not provide benefits for any illness, injury, disease or other condition for which a Third Party is or may be liable or legally responsible by reason of negligence, an act or omission, an intentional act or breach of any legal obligation on the part of that Third Party. Charges and/or expenses incurred by a Participant or Dependent for which a Third Party is liable or responsible are not covered under any benefits provided in this Plan. However, if a Participant (including an eligible Dependent) is injured through the act or omission of another party, Plan benefits might be advanced only on the following conditions:

(j) The Participant or Dependent agrees that as a condition precedent to being advanced any Plan benefits, the Participant or Dependent will notify the Plan office reasonably in advance if any claims incurred under the Plan are the result of an accident, injury, disease or other condition for which a Third Party is or may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that Third party;

(iv) The Participant or Dependent will be required to pay to the Plan or any entity providing benefits (such as Kaiser) immediately any proceeds received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or any other insurance) arising out of any claims for damages by the individual or his or her heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the Third Party may be responsible;

(v) Any Participant or Dependent who accepts payments from the Plan agrees that by doing so he or she is making a present assignment of his or her rights against such third party (or their respective insurers) to the extent the payments made by the Plan. These rules are automatic, but the Plan

also may require that any participant or dependent sign an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require; and

(vi) Any Participant or Dependent who refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. Any Participant or Dependent who receives benefit payments and later fails to reimburse the Plan as set forth above will be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the employee or dependent has failed to reimburse, including reasonable interest on such unpaid funds.

2. Granting of First Right of Recovery, Reimbursement and Restitution. As a condition of receiving the benefits under the Plan, as described in above, the Participant or Dependent grants specific and first rights of subrogation, reimbursement, and restitution to the Plan. Such rights shall come first and are not adversely impacted in any way by:

(i) The extent to which the Participant or Dependent recovers his full damages and/or attorneys' fees; or

(ii) How such recovery may be itemized, structured, allocated, denominated, or characterized; e.g., without regard to any characterization as a recovery for such matters as lost wages, damages, attorneys' fees, etc. rather than for medical expenses, the type of property or the source of the recovery, including any recovery from the payment or compromise of a claim (including an insurance claim), a judgment or settlement of a lawsuit, resolution through any alternative dispute resolution process (including arbitration), or any insurance (including insurance on the Participant or Dependent, no-fault coverage, or uninsured and/or underinsured motorist coverage).

Such reimbursement, restitution and subrogation rights shall extend to any property (including money) that is directly or indirectly in any way related to the Plan benefits described above. Without in any way limiting the preceding, the Participant or Dependent agrees to subrogate the Plan to any and all claims, causes of action, or rights that the Participant or Dependent has or that may arise against any person, corporation, and/or other entity who has or who may have caused, contributed to and/or aggravated the injury or condition for which the Participant or Dependent claims an entitlement to benefits under the Plan, and to any claims, causes of action, or rights the Participant or Dependent may have against any other no-fault coverage, uninsured and/or underinsured motorist coverage, or any other insurance coverage or fund.

3. Granting of Lien. By accepting benefit payments from the Plan, any Participant or dependent agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the employee's own carrier for uninsured motorist's coverage. The Participant or Dependent shall furnish any information or assistance and execute any documents that the Board of Trustees or its delegates may require or request to facilitate enforcement of their rights under this Section. The Participant and Dependent agree not to take action that may prejudice or interfere with the Plan's rights under this Section. An equitable lien shall exist in favor of the Plan upon all sums of money recovered by the Participant or dependent against the third party. The lien may be filed with the third party, the third party's agents, or the court and the lien shall exist without regard to the identity of the property's source or holder at any particular time or whether at any particular time the property exists, is segregated, or whether the Participant or Dependent has any rights to it. The Participant or dependent (including its agents and attorney's) shall do nothing to prejudice the Plan's right as described above without the Plan's written consent.

4. Creation of Construction Trust. The Participant or Dependent agrees that until such lien is completely satisfied, the holder of any such property (whether the Participant or Dependent, his/her attorney, an account or trust set up for the Participant or Dependent, an insurer, or any other holder) is required to hold such property as the Plan's constructive trustee. As such, the constructive trustee agrees to immediately pay

over such property to or on behalf of the Plan pursuant to its direction to the extent necessary to satisfy the equitable lien.

5. **Plan's Rights are Not Diminished**. The Plan's right to subrogation, reimbursement, restitution, to a lien, and as a beneficiary of a constructive trust shall in no way be affected, reduced, compromised, or eliminated by any doctrines limiting its rights (equitable or otherwise) such as the make-whole doctrine, contributory or comparative negligence, the common fund doctrine, or any other defense.

6. **Agreement Not to Alienate Rights or Property**. The Participant and Dependent agrees:

- Not to assign any rights or causes of action he/she may have against others (including those under insurance policies) related to this section without the express written consent of the Plan;
- To take possession of any property subject to the Plan's lien in his/her own name, place it in a segregated account within his/her control (at least in the amount of the equitable lien), and not to alienate it or otherwise take any action so that it is not in his/her possession prior to the satisfaction of such lien;
- That if such property is not in his/her possession (other than in possession by or on behalf of the Plan), to immediately take whatever steps possible to regain possession or have possession transferred to or on behalf of the Plan pursuant to its direction; and
- Agrees to cooperate with the Plan and take any action that may be necessary to protect its interests herein.

7. **No Duty to Independently Sue or Intervene**. While the Plan's subrogation rights include the right to file an independent legal action or alternative dispute resolution proceeding against such Third Party (or to intervene in one brought by or on the participant or dependent's behalf), it has no obligation to do so.

8. **Your Failure to comply with the Plan's Rights**!

IMPORTANT: **IF YOU OR YOUR DEPENDENT FAIL TO COMPLY WITH THE PLAN'S RIGHT OF REIMBURSEMENT AND SUBROGATION DESCRIBED IN THIS SECTION, THE PLAN MAY OFFSET THE AMOUNT WHICH SHOULD HAVE BEEN REIMBURSED AGAINST ANY FUTURE BENEFIT PAYMENTS THAT MAY OTHERWISE BE PAYABLE UNDER THE PLAN TO YOU OR YOUR DEPENDENT.**

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

B. COORDINATION OF BENEFITS WITH OTHER PLANS.

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans are paying for the same claim. To help control costs, this Plan provides a Coordination of Benefits provision. This provision affects all of you and/or your eligible dependents different benefits under the Plan.

General Coordination of Benefits Rule: Benefits payable under more than one group program shall be integrated to avoid payment of more than 100% of allowable expenses. If a covered Participant or dependent is entitled to benefits from another plan, the HMOs, insurance companies or other entities likely have rules on which plan is primary or secondary and who pay first. You should consult with these entities to determine the rule.

If any such contract does not provide for coordination of benefits, the following shall apply:

1. Employee's Plan Primary & Birthday Rule. 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.
4. Dependents with Dual Coverage. If your dependent is also eligible as an employee for medical or dental benefits under another health plan or program, that plan or program shall be primary over benefits provided by this Plan. If your dependent child is entitled to coverage under two or more health plans, the plan covering the custodial parent whose birthday falls earlier in the calendar year will be primary.

You may not reject coverage under another Plan, HMO and/or insurance company and/or not enroll in such other Plan, HMO and/or insurance company and then expect this Plan to be primary with respect to payment of your benefits. The other Plan, HMO and/or insurance company would be primary (or you would be responsible for such claims/payments if they refuse such given your failure to enroll or action of un-enrolling).

C. CONSTRUCTION.

The validity of the Plan or any of its provisions will be determined under and will be construed according to ERISA and other federal law and, to the extent permissible, according to the laws of the State of California. This Plan is intended to be construed as a whole, but in the event any provision of this Plan is held illegal or invalid for any reason, such determination will not affect the remaining provisions of this Plan and the Plan will be construed and enforced as if said illegal or invalid provision had never been included.

D. NO VESTED RIGHT.

Nothing in this Plan shall be construed as giving Employees, retired or terminated Employees, Dependents or any other person a vested right to continued coverage under this Plan. The Trustees retain full authority to amend or terminate coverage at any time and/or to increase premiums.

E. FACILITY OF PAYMENT.

Any death benefit payable to a minor may be paid to the legally appointed guardian of the minor, or if there is no such guardian, to such adult or adults as have complied with the requirements of California or other applicable law for receipt of such benefit on behalf of the minor, after which the Plan shall have no further obligations with respect to such minor.

F. AVAILABLE ASSETS FOR BENEFITS.

Benefits provided by this Plan can be paid only to the extent that the Fund has available adequate resources for such payments. No contributing Employer has any liability, directly or indirectly, for such payments. No contributing Employer has any liability, directly or indirectly, for providing the benefits established hereunder beyond the obligation to make contributions and other changes as required in the Collective Bargaining Agreement, if applicable.

In at any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any contributing Employer or any U.A. Local to make benefit payments or contributions in order to provide for such benefits. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any contributing Employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

G. INCOMPETENCE OR INCAPACITY.

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

H. GENDER AND NUMBER.

Whenever any words are used in this Plan in the masculine gender, they should be construed as though they were also used in the feminine gender and the singular the plural where they would so apply.

I. 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.

J. NO ASSIGNMENT.

Although the Plan may make payments directly to providers, such payments do not make a provider an assignee or otherwise confer on the provider any rights under the Plan or ERISA. Except as permitted under the Plan's Qualified Domestic Relations Order ("QDRO") provisions, the rights and benefits under the Plan's benefits cannot be assigned to third parties for any reason.

K. MISCELLANEOUS PROVISIONS.

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

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

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

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

The Plan is not responsible for maintaining the relationship between the Participant and the current health care provider(s). Agreements between the Plan and the current health care provider(s) permit termination 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 Plan is a party.

WARNING: BENEFITS CAN BE REDUCED OR ELIMINATED

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

L. PROCEDURE FOR HANDING PROPOSED ORDERS OR INQUIRIES.

Written Request for Information. Inquiries concerning the potential benefits of an alternate recipient should be made in writing to the Trust 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 Trust 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.

XIV. AMENDMENT AND TERMINATION OF THE PLAN

A. AMENDMENTS & MANDATORY AMENDMENTS.

The Plan may be amended in whole or in part at any time by the Board of Trustees and all persons with rights or obligations hereunder shall be bound thereby. Benefit levels and amounts may be changed at any time.

Amendments of the Trust or Plan shall be mandatory in the following situations: When necessary to assure compliance with ERISA or other applicable laws; when necessary to assure the tax-deductibility of contributions hereto under federal and state income tax laws; and when necessary to assure that this Trust remains tax exempt.

B. TERMINATION.

The Board of Trustees may terminate the Plan at any time subject to the Trust Agreement and applicable Collective Bargaining Agreements.

Upon termination of the Trust, all obligations shall first be satisfied. The Board of Trustees shall thereupon use the remaining Trust assets to provide Plan benefits in such manner as the Plan my provide, or in the absence of a Plan provision, to continue to provide Plan benefits in a manner permitted by ERISA for so long as Trust assets permit.

C. TRANSFER OF ASSETS TO ANOTHER BENEFIT TRUST.

Notwithstanding anything above to the contrary, the Board of Trustees may transfer the Trust assets or any portion thereof to the Trustees of any other trust or trusts which provide similar benefits.

XV. INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

1. **Name of the Plan**: **Solano-Napa Counties Electrical Workers Health and Welfare Plan**

2. **Address of the Plan**: 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
Telephone (925) 208-9980/ Toll Free (866) 544-9880

3. **Type of Plan**: This is a health and welfare Plan that provides life insurance, accidental death and dismemberment insurance, vision, dental, hospital and medical benefits to eligible employees, retirees, and their dependents.

4. **Type of Plan and Method of Fund Benefits**: This Plan is administered by the Joint Board of Trustees. The Plan is funded by employer contributions as provided for in the collective bargaining agreements. Benefits are provided from a trust fund and insurance contracts through ULLICO, Standard Life Insurance Company, Kaiser Foundation Health Plan, United Health Care PPO Dental Plan, and Vision Service Plan.

5. **Sponsoring Organizations & Availability of Collective Bargaining Agreements**: The Plan is maintained in accordance with collective bargaining agreements between N.E.C.A. and Local 180 of the International Brotherhood of Electrical Workers Union. A copy of the applicable collective bargaining agreement is available for examination and may be obtained upon request to the Trust Fund office.

6. **Contributions**: Contributions to provide Plan benefits are paid by the contributing employers in accordance with their bargaining agreements at a fixed hourly rate. The Trust Fund office will provide you, upon written request, information as to whether a particular employer is contributing to the Plan on behalf of participants working under the collective bargaining agreement and, if the particular employer is contributing to the Plan, the employer's address.

7. **Plan Administrator.** The Board of Trustees is the Plan Administrator of the Plan. The Board of Trustees is responsible for ensuring that information regarding the Plan is reported to governmental agencies and disclosed to Plan Participants and beneficiaries in accordance with ERISA. The Plan Administrator's address is P.O. Box 1306 San Ramon, California 94583.

8. **Plan Year**: The Plan year is the twelve-month period ending each **February 1st** and ending on the following **January 31st**.

9. **Employer Identification Number**: 94-6085742

10. **Plan Number**: 501

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

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

In addition to creating rights for Plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the Employee Benefit Plan. The individuals who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the 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 benefits under the plan or exercising your rights under ERISA. If your claim for benefits is denied or ignored, in whole or in part, you must receive a written explanation for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest summary 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 $110.00 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a State or Federal Court. Pursuant to the Plan Rules there is a **one (1) year statute of limitation,** from the time benefits are provided or denied, to file suit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order or domestic relations order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court.

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

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone

directory or the Division of Technical Assistance and Inquiries, EBSA Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

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

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

12. Names and Addresses of the Board of Trustees: The names and address of the Trustees are below.

Employer Trustees

Greg Armstrong
c/o Northern California Chapter, NECA
7041 Koll Center Parkway, Suite 100
Pleasanton, CA 94566

Patti Long
c/o Long Electric Company
450 Technology Way
Napa, CA 94558

Jess Zuniga
c/o Zeco Electric
3433 Broadway Street, Suite B1
American Canyon, CA 94503

Ruben Perez
c/o Napa Electric
2240 Brown Street
Napa, CA 94558

Scot Van Buskirk
c/o Northern California Chapter, NECA
7041 Koll Center Parkway, Suite 100
Pleasanton, CA 94566

Union Trustees

Kevin Coleman
c/o IBEW Local 180
720B Technology Way
Napa, CA 94558

Herb Watts
c/o IBEW Local 180
720B Technology Way
Napa, CA 94558

Steve Garcia
c/o IBEW Local 180
720B Technology Way
Napa, CA 94558

Brian Hansen
c/o IBEW Local 180
720B Technology Way
Napa, CA 94558

13. Name and Address of Contract Administrator:
BeneSys Administrators
2610 Crow Canyon Road, Suite 200
P.O. Box 1306
San Ramon, California 94583
Phone (925) 208-9980/Toll Free (866) 544-9880
Fax (925) 362-8564
E-mail: staff@ibew180benefitfunds.org

14. Name and Address of Agent for Service of Legal Process:

Neyhart, Anderson, Flynn & Grosboll APC
Attn: Richard K. Grosboll & Lois H. Chang
Attorneys at Law
369 Pine Street, Suite 800
San Francisco, CA 94104-3323
Telephone: (415) 677-9440
E-mails: RGrosboll@neyhartlaw.com and LChang@neyhartlaw.com

XXIII. HIPAA Disclosure of Providers

In accordance with the disclosure requirements of the Health Insurance Portability and Accountability Act, we are informing you of the names and addresses of all Heath Providers for the Plan and their roles (i.e., whether they guarantee the payment of benefits or provide administrative services). **The list below is subject to change. Please contact the Trust Fund Office for the most current list.**

List of Providers

United Healthcare PPO Dental
2300 Clayton Rd., Suite 1000
Concord, CA 94520
Provides prepaid dental benefits with guaranteed payment of these benefits.
Fully insures life and accidental death and dismemberment benefits for eligible participants.

Kaiser Foundation Health Plan
1800 Harrison Street, 13th Floor
Oakland, CA 94120
Provides prepaid medical benefits with guaranteed payment of these benefits.

Vision Service Plan
333 Quality Drive
Rancho Cordova, CA 95670
Phone: 1-800-877-7195
Administers the insured vision plan for participants and dependents.

The Act also requires that we inform you of the U.S. Department of Labor's address in Washington, D.C. If you have any questions about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in the 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. Additional information regarding your ERISA rights may be found in your Summary of Benefits booklet under "Statement of ERISA Rights".