HEALTH & WELFARE PLAN
SUMMARY PLAN DESCRIPTION

IBEW LOCAL 595

FEBRUARY 1, 2021

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From time to time, important changes regarding your benefits will be made to IBEW Local 595 Health and Welfare Plan and the information in this booklet. You will receive written notification of these changes. Please keep these written notices with this booklet and check with the Plan Office regarding any changes to the information provided in this booklet. You may also visit www.IBEW595benefits.org to obtain information about changes and amendments.

THIS DOCUMENT IS WRITTEN IN ENGLISH.
IF YOU HAVE ANY DIFFICULTY UNDERSTANDING THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, PLEASE CONTACT THE PLAN OFFICE.

IBEW LOCAL 595

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CONTACTING THE PLAN OFFICE

Should you or one of your Dependents wish
to contact the Plan Office, call or write:

BENESYS ADMINISTRATORS
IBEW Local 595 Health & Welfare Plan Manager
P.O. Box 3420
San Ramon, CA 94583

(888) 512-5863 or (925) 208-9996
Fax: (925) 362-8564

On-Site Address:
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

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IMPORTANT NOTICE TO EMPLOYEES, RETIREES, SPOUSES AND DEPENDENTS

The Board of Trustees shall have the exclusive right, in their sole and absolute discretion, to administer or terminate any provisions of the Plan, this Summary Plan Description and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the foregoing, the Board of Trustees shall have the sole and absolute discretionary authority:

1. To take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;
2. To formulate, interpret and apply rules and policies necessary to administer the Plan in accordance with its terms;
3. To decide questions (including legal or factual questions) relating to the calculation and payment of benefits under the Plan;
4. To resolve and/or clarify any ambiguities, inconsistencies and/or omissions arising under the Plan or other Plan documents; and
5. To process and approve or deny benefit claims and rule on any benefit exclusions.

All determinations made by the Board of Trustees with respect to any matter arising under the Plan, this Summary Plan Description, and any other Plan documents shall be final and binding on all parties.

From time to time the Fund Manager may mail you updated materials in order to inform you and your Dependents of any changes in benefits. It is important that you file all documents received in the back of this booklet and note the affected benefit provisions.

NOTICE TO PARTICIPANTS FROM BOARD OF TRUSTEES OF INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL 595 HEALTH & WELFARE PLAN

The Board of Trustees of the International Brotherhood of Electrical Workers Local 595 Health & Welfare Plan ("the Plan") is pleased to present this Summary Plan Description ("SPD"). This Plan was established for you as a result of collective bargaining between various Employers and Local 595 of the International Brotherhood of Electrical Workers (IBEW). Contributions are made by your Employer into a trust fund to provide certain health and welfare benefits for eligible Active employees, Retirees and their Dependents.

The Plan is a successor plan to the Electrical Workers Area Health & Welfare Plan and the Electrical Workers Area Retiree Health & Welfare Plan (collectively, "Area Plans"). All of the benefits provided under the predecessor Area Plans will be treated as though they were paid under this Plan for purposes of determining any annual deductibles, coinsurance levels, and Plan maximums. However, not all benefits provided under this Plan were provided under the predecessor Area Plans.

Please read this booklet carefully. In addition to summarizing the benefits to which you may be entitled, including hospital-medical-surgical, dental, prescription drug, group life insurance and related benefits, it describes the requirements for Plan eligibility, claims and appeals procedures, and other important Plan information. This booklet is both the Plan Document and SPD.

The information in this booklet is subject to, and in no way modifies or interprets, the provisions of the policies of insurance and contracts between the Plan and the insurance carriers or providers of care. Supplemental booklets describing the benefits and services provided under each Health Maintenance Organization

("HMO") or supplemental benefit program offered through the Plan are available without cost from the Plan Office upon request. The supplemental booklets, which are incorporated by reference herein, describe the benefits provided, any additional requirements other than Plan eligibility that must be met to qualify for those benefits, whether dependent coverage is provided, information about claims and review procedures, and other matters.

The Plan is administered by the Board of Trustees, subject to the terms and conditions of the Plan and provider agreements as well as to any rules and regulations the Trustees may adopt from time to time. The Board of Trustees determines policies and benefits in keeping with the assets and income of the Plan.

A summary of the benefits provided is outlined in Section I, Schedule of Benefits. The benefits described herein are not guaranteed (i.e., not vested) and will be provided only to the extent of the funds available. The benefits can be modified or terminated at any time by a revision of the applicable Collective Bargaining Agreement or by action of the Board of Trustees.

You may obtain additional information about your Plan including HMO benefit information and/or claim forms from the Plan Office. Any questions that you may have regarding your eligibility or benefits should also be directed to the Plan Office. The Fund Manager of the Plan is BeneSys Administrators, located at 7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566. Only the **written statements** of the Fund Manager and its authorized agents and legal representatives will be determined to be authorized information. Oral statements or the statements of other representatives are not authoritative sources of information regarding Plan benefits and will not be binding on the Board of Trustees.

It is your obligation to keep the Fund Manager informed of any change in address, beneficiary or Dependent status, and to provide any other requested information pertinent to the administration of the Plan. Failure to provide accurate information may result in denial of benefits and/or loss of eligibility. In addition, because loss of eligibility may result if any required payments are not received by the Trust Fund in a timely fashion, it is essential that you understand the rules for making monthly payments. If you or your Dependents are retired and eligible for Medicare, you should refer to the Medicare Enrollment rules starting in Section II.B.7. You must notify the Plan Office immediately upon becoming eligible for Medicare.

This document provides a general description, written in non-technical language, of the important provisions of this Plan. **Again, please read it carefully.** The Plan benefits described in this document are governed by the provisions contained in the Agreement and Declaration of Trust for the IBEW 595 Health & Welfare Plan and the contracts from various providers. Nothing in this document is meant to interpret or extend or change in any way the provisions of those documents.

Sincerely,

THE BOARD OF TRUSTEES

I. SCHEDULE OF BENEFITS

A. BENEFITS FOR ACTIVE EMPLOYEES & THEIR DEPENDENTS

(Refer to Eligibility Rules in Section II.A (Actives), and Section II.C (Dependents))

1. MEDICAL AND HOSPITAL BENEFITS

Base Plan. There is a "Base" medical plan (Kaiser HMO as of the publication date of this booklet, but check with the Plan Office for the current base medical plan).

Buy Up Plan Option. In addition, the Plan offers a "Buy Up" option that allows Participants to enroll in a different plan option other than the Base plan. These are United Healthcare and Self-Funded Indemnity Plan options. To enroll, you must "buy up" to these plan options by paying the monthly Buy Up as established by the Board of Trustees, by authorizing automatic deductions from your Health Reimbursement Account Plan ("HRA") each month. If there are insufficient funds in your HRA, you must make direct payment of the buy up amount before each month begins. The buy up cannot be paid out of your Dollar Bank reserve.

Additional Deductible Indemnity Medical Plan. If you choose the "Buy Up" option described above, but you do not have sufficient HRA funds or fail to submit the full and timely buy up payment to the Plan Office directly, you will be automatically defaulted into the "Additional Deductible Indemnity Medical Plan." The Additional Deductible Indemnity Medical Plan offers indemnity medical benefits, but **without** dental and vision coverage. If you default, you will not be able to change Plan options for twelve months.

BENEFIT PROVIDED	DESCRIPTION
Self-Funded Indemnity Plan	Medical, Hospital, Substance Abuse, and Mental Health benefits are self-funded and administered under the Indemnity Plan. The Plan has a contract with Anthem Blue Cross, a Preferred Provider Organization ("PPO" network) which provides a list of Doctors from which Indemnity Plan Participants may select. The Plan pays 100% of all Preventive Care "in-network" Covered Charges (see Section IV.A.1.(f)(xxxv) for details on Preventive Care Covered Charges). A complete list of the Preventive Care health services can be found at

	www.HealthCare.gov/center/regulations/prevention.html The Plan pays 80% of all other non-Preventive Care "in-network" Covered Charges and 60% of all other "out-of-network" Covered Charges (including "out-of-network" Preventive Care Covered Charges), after an annual calendar year deductible of $200 per person ($400 per family). There is no **lifetime** or **annual** maximum dollar amount for Covered Charges that are considered "essential health benefits" under the Patient Protection Affordable Care Act for both Inside Construction and Motor Shop employees. After a Participant incurs $10,000 or more in Covered Charges in a calendar year, the Plan pays 100% of the balance of Covered Charges incurred during the remainder of the calendar year.
Additional Deductible Indemnity Medical Plan	Medical, Hospital, Substance Abuse, and Mental Health benefits are self-funded and administered under the Additional Deductible Indemnity Medical Plan. The Plan has a contract with Anthem Blue Cross, a Preferred Provider Organization ("PPO" network) which provides a list of Doctors from which Indemnity Plan Participants may select. The Plan pays 100% of all Preventive Care "in-network" Covered Charges (see Section IV.A..(f)(xxxv) for details on Preventive Care Covered Charges). A complete list of the Preventive Care health services can be found at www.HealthCare.gov/center/regulations/prevention.html The Plan pays 80% of all other non-Preventive Care "in-network" Covered Charges and 60% of all other "out-of-network" Covered Charges (including "out-of-network" Preventive Care Covered Charges), after an annual calendar year deductible of $3,554 per person ($3,754 per family). There is no **lifetime** or **annual** maximum dollar amount for Covered Charges that are considered "essential health benefits" under the Patient Protection Affordable Care Act for both Inside Construction and Motor Shop employees. After a Participant incurs $10,000 or more in Covered Charges in a calendar year, the Plan pays 100% of the balance of Covered Charges incurred

	during the remainder of the calendar year. Note: This option does **not** provide dental or vision benefits.
United Healthcare ("UHC") HMO	Medical, Hospital, Substance Abuse, and Mental Health benefits are provided through UHC HMO. Coverage and benefit availability is dependent on UHC's service areas.
Kaiser Health Plan HMO	Medical, Hospital, Substance Abuse, and Mental Health benefits provided through Kaiser Health Plan HMO. Coverage and benefit availability is dependent on Kaiser's service areas. Note: Prescription drugs are covered through the Kaiser program.

2. SUPPLEMENTAL BENEFITS	
BENEFIT PROVIDED	**DESCRIPTION**
Prescription Drug Card Program	Prescription drug benefits are provided through Optum Rx's prescription drug card program. (See separate Optum Rx booklet for details.) **30-Day Retail Supply:** Generic - $5 co-pay; Brand ("Optum Rx Preferred") - $20 co-pay; and Brand ("Non-Preferred") - $35 co-pay **90-Day Mail Order:** Generic - $10 co-pay; Brand (Optum Rx Preferred) - $40 co-pay; and Brand (Non-Preferred) - $70 co-pay **Mandatory Generic Substitution:** The Plan will pay the amount equal to the generic prescription drug if there is a generic alternative available, unless special circumstances apply. Higher-cost generic products will be excluded when a lower-cost generic is available. This is also true for higher-cost brand products when a generic,

	clinically equivalent, lower-cost option is available. Note: Only members enrolled in the Indemnity Plan and UHC are entitled to this benefit. Kaiser enrollees have prescription drug benefit coverage through the Kaiser program.
Delta Dental Plan	**Dental benefits are not available to Participants enrolled in the Additional Deductible Medical Plan.** Dental benefits are provided through Delta Dental Plan. (See separate Delta Dental booklet for details.) The Plan pays: 100% of the Delta Dental provider fee for diagnostic and preventive benefit and 80% of the Delta Dental provider fee for basic benefits. $2,000 per calendar year maximum $2,500 lifetime maximum for orthodontic benefits $25 per individual and $75 per family calendar year deductible (diagnostic and preventive services from a PPO dentist are exempt from the deductible)
United Healthcare ("UHC") Dental	**Dental benefits are not available to Participants enrolled in the Additional Deductible Medical Plan.** UHC Dental is a closed panel dental provider and may be elected in lieu of Delta Dental. (See separate UHC Dental booklet for details.)
Vision Benefits	**Vision benefits are not available to Participants enrolled in the Additional Deductible Medical Plan.** Vision benefits are provided through Vision Service Plan ("VSP"). (See separate VSP booklet for details.) Exam every 12 months Lenses, including contacts, and frames every 24 months

	Safety glasses, one pair every 24 months $20 co-pay
Hearing Benefit (For eligible L-595 and L-595 Motor Shop Active employees only – i.e., not Dependents)	One custom fit hearing protection plug for Active members. Plan reimburses up to the amount of $100 per lifetime per Participant.
Death Benefit (For eligible L-595 and L-595 Motor Shop Active employees only – i.e., not Dependents)	Plan pays $15,000
Accidental Death and Dismemberment Benefit (For eligible L-595 and L-595 Motor Shop Active employees only – i.e., not Dependents)	The Plan pays up to $15,000, depending on type of accident and bodily harm.

3. LONG-TERM DISABILITY PROGRAM
SUSPENDED as of October 1, 2011.

4. MEMBER ASSISTANCE PROGRAM	
BENEFIT PROVIDED	**DESCRIPTION**
Member Assistance Program ("MAP") (For eligible Active employees and	Member assistance benefits are free confidential counseling and referral services designed to help members and persons in their households resolve personal problems that may be interfering with

their household members only)	work or home life. (See separate MAP booklet for details.) The Plan provides up to 8 sessions per incident for Active employees and all persons in their households. This benefit is in addition to mental health/substance abuse benefits that are available under medical benefits.

5. LIVEHEALTH ONLINE ("LHO") CARE SERVICE PROGRAM – INDEMNITY PLAN ENROLEES ONLY	
BENEFIT PROVIDED	**DESCRIPTION**
LIVEHEALTH ONLINE (For Self-Funded Indemnity Plan and Additional Deductible Indemnity Medical Plan enrollees)	LiveHealth Online is a non-emergency care service benefit for Indemnity Plan enrollees to have access to medical doctors, psychologists, and therapists who are available 24 hours, 365 days per year and who can provide a diagnosis, treatment, or prescriptions if needed. (See separate LHO materials from Anthem for details on how to access this benefit.)

B. BENEFITS FOR EARLY (NON-MEDICARE*) RETIREES, THEIR DEPENDENTS & THEIR SURVIVING SPOUSES [MOTOR SHOP EXCLUDED]

(Refer to Eligibility Rules in Section II.B (Retirees), and Section II.C (Dependents))

1. MEDICAL AND HOSPITAL BENEFITS	
BENEFIT PROVIDED	**DESCRIPTION**
Self-Funded Indemnity Plan	Medical, Hospital, Substance Abuse, and Mental Health benefits are self-funded and administered under the Indemnity Plan. The Plan has a contract with Anthem Blue Cross, a Preferred Provider

	Organization ("PPO" network) which provides a list of Doctors from which Indemnity Plan Participants may select. The Plan pays 100% of all Preventive Care "in-network" Covered Charges (see Section IV.A.1.(f)(xxxv) for details on Preventive Care Covered Charges). A comprehensive list of Preventive Care health services can be found at www.HealthCare.gov/center/regulations/prevention.html The Plan pays 80% of all other non-Preventive Care "in-network" Covered Charges and 60% of all other "out-of-network" Covered Charges (including "out-of-network" Preventive Care Covered Charges), after an annual calendar year deductible of $200 per person ($400 per family). There is no **lifetime** or **annual** maximum dollar amount for Covered Charges that are considered "essential health benefits" under the Patient Protection Affordable Care Act for both Inside Construction and Motor Shop employees. After a Participant incurs $10,000 or more in Covered Charges in a calendar year, the Plan pays 100% of the balance of Covered Charges incurred during the remainder of the calendar year.
Additional Deductible Indemnity Medical Plan	Medical, Hospital, Substance Abuse, and Mental Health benefits are self-funded and administered under the Additional Deductible Indemnity Medical Plan. The Plan has a contract with Anthem Blue Cross, a Preferred Provider Organization ("PPO" network) which provides a list of Doctors from which Indemnity Plan Participants may select. The Plan pays 100% of all Preventive Care "in-network" Covered Charges (see Section IV.A.1.(f)(xxxv) for details on Preventive Care Covered Charges). A complete list of the Preventive Care health services can be found at www.HealthCare.gov/center/regulations/prevention.html The Plan pays 80% of all other non-Preventive Care "in-network" Covered Charges and 60% of all other "out-of-network" Covered Charges (including "out-of-network" Preventive Care Covered Charges), after an annual calendar year

	deductible of $3,554 per person ($3,754 per family). There is no **lifetime** or **annual** maximum dollar amount for Covered Charges that are considered "essential health benefits" under the Patient Protection Affordable Care Act for both Inside Construction and Motor Shop employees. After a Participant incurs $10,000 or more in Covered Charges in a calendar year, the Plan pays 100% of the balance of Covered Charges incurred during the remainder of the calendar year. Note: This option does **not** provide dental or vision benefits, but is available without a required "buy-up".
United Healthcare ("UHC") HMO	Medical, Hospital, Substance Abuse, and Mental Health benefits provided through UHC HMO. Coverage and benefit availability is dependent on UHC's service areas.
Kaiser Health Plan HMO	Medical, Hospital, Substance Abuse, and Mental Health benefits provided through Kaiser Health Plan HMO. Coverage and benefit availability is dependent on Kaiser's service areas. Note: Prescription drugs are covered under the Kaiser program.

2. SUPPLEMENTAL BENEFITS	
BENEFIT PROVIDED	**DESCRIPTION**
Prescription Drug Card Program	Prescription drug benefits are provided through Optum Rx prescription drug card program. (See separate Optum Rx booklet for details.) **30-Day Retail Supply:** Generic - $5 co-pay; Brand ("Optum Rx Preferred") - $20 co-pay; and

	Brand ("Non-Preferred") - $35 co-pay **90-Day Mail Order:** Generic - $10 co-pay; Brand (Optum Rx Preferred) - $40 co-pay; and Brand (Non-Preferred) - $70 co-pay **Mandatory Generic Substitution:** The Plan will pay the amount equal to the generic prescription drug if there is a generic alternative available, unless special circumstances apply. Higher-cost generic products will be excluded when a lower-cost generic is available. This is also true for higher-cost brand products when a generic, clinically equivalent, lower-cost option is available. Note: Only members enrolled in the Indemnity Plan and UHC HMO are entitled to this benefit. Kaiser enrollees have prescription drug benefit coverage through the Kaiser program.
Delta Dental Plan	**Dental benefits are not available to Participants enrolled in the Additional Deductible Medical Plan.** Dental benefits are provided through Delta Dental Plan. (See separate Delta Dental booklet for details.) The Plan pays: 100% of the Delta Dental provider fee for diagnostic and preventive benefit and 80% of the Delta Dental provider fee for basic benefits. $2,000 per calendar year maximum $2,500 lifetime maximum for orthodontic benefits $25 per individual and $75 per family calendar year deductible (diagnostic and preventive services from a PPO dentist are exempt from the deductible)
United Healthcare ("UHC") Dental	**Dental benefits are not available to Participants enrolled in the Additional Deductible Medical Plan.** UHC Dental is a closed panel dental provider and may be elected in lieu of Delta Dental. (See separate UHC Dental booklet for details.)

Vision Benefits	**Vision benefits are not available to Participants enrolled in the Additional Deductible Medical Plan.** Vision benefits are provided through Vision Service Plan ("VSP"). (See separate VSP booklet for details.) Exam every 12 months Lenses and frames every 24 months Safety glasses, one pair every 24 months $20 co-pay

3. LIVEHEALTH ONLINE ("LHO") CARE SERVICE PROGRAM – INDEMNITY PLAN ENROLLEES ONLY

BENEFIT PROVIDED	DESCRIPTION
LIVEHEALTH ONLINE (For Self-Funded Indemnity Plan and Additional Deductible Indemnity Medical Plan enrollees)	LiveHealth Online is a non-emergency care service benefit for Indemnity Plan enrollees to have access to medical doctors, psychologists, and therapists who are available 24 hours, 365 days per year and who can provide a diagnosis, treatment, or prescriptions if needed. (See separate LHO materials from Anthem for details on how to access this benefit.)

C. BENEFITS FOR MEDICARE* RETIREES, THEIR DEPENDENTS & THEIR SURVIVING SPOUSES [MOTOR SHOP EXCLUDED]

(Refer to Eligibility Rules in Section II.B (Retirees), and Section II.C (Dependents))

1. MEDICAL AND HOSPITAL BENEFITS	
BENEFIT PROVIDED	**DESCRIPTION**
United Healthcare ("UHC") Medicare Advantage National PPO Plan	Medical and Hospital benefits are provided through UHC Medicare Advantage National PPO Plan, which is designed to help meet the health care needs of people who are enrolled in both Medicare Parts A and B. UHC Medicare Advantage National PPO Plan acts as the secondary payer to Medicare once Medicare pays the first 80% of approved Medicare charges for Doctor office visits. (See separate booklet for details.) Note: Prescription drugs are covered under the UHC Medicare Advantage National PPO Plan.
Kaiser Senior Advantage	Medical benefits provided through Kaiser Senior Advantage, an HMO, may be elected in lieu of medical benefits offered under the UHC Medicare Advantage National PPO Plan. (See separate booklet for details.) Coverage and benefit availability is dependent on Kaiser's service areas. Note: Prescription drugs are covered under the Kaiser Senior Advantage program.

2. SUPPLEMENTAL BENEFITS	
BENEFIT PROVIDED	**DESCRIPTION**
Delta Dental Plan (Not available to L-595 Motor Shop Retirees, their Dependents or surviving spouses)	Dental benefits are provided through Delta Dental Plan. (See separate Delta Dental booklet for details.) The Plan pays: 100% of the Delta Dental provider fee for diagnostic and preventive benefit and 80% of the Delta Dental provider fee for basic benefits. $2,000 per calendar year max $2,500 lifetime max for orthodontic benefits $25 per individual and $75 per family calendar year deductible (diagnostic and preventive services from a PPO dentist are exempt from the deductible)
United Healthcare (UHC) Dental	UHC Dental is a closed panel dental provider and may be elected in lieu of Delta Dental. (See separate UHC Dental booklet for details.)

***If a Medicare-eligible Retiree enrolls in UHC Medicare Advantage National PPO Plan, his or her non-Medicare-eligible spouse must enroll in the Indemnity Plan. If the non-Medicare-eligible Retiree enrolls in the UHC HMO Plan, then the Medicare-eligible spouse must enroll in the UHC Medicare Advantage National PPO Plan.**

II. ELIGIBILITY FOR BENEFITS

NOTE: These Eligibility Rules are applicable to Local 595 Actives, Retirees & their Dependents only.

A. IF YOU ARE AN ACTIVE MEMBER

All persons who are Employees of a Contributing Employer, or who are otherwise entitled to participate in the Plan or to maintain Plan participation are Active members of the Plan, provided the following eligibility rules set forth in paragraphs 1-6 below are followed.

1. **Dollar Bank System.** A "Dollar Bank" is a reserve account system for each Active member and is kept by the Plan Office. Your Dollar Bank is credited with employer contributions made on your behalf at the negotiated hourly rate, up to your "Dollar Bank Ceiling" described below in subparagraph (b). For each month of Plan coverage, your Dollar Bank is charged the "Actual Monthly Plan Cost" ("AMPC") as defined below in subparagraph (a). The AMPC is subject to change at the discretion of the Trustees. Note that Dollar Bank accounts cannot be used to pay for the Buy Up medical plan option.

For months in which you do not receive employer contributions at least equal to the AMPC, the Dollar Bank reserve, if sufficient, is charged the shortfall so that your coverage is not interrupted. For months in which you earn at least the AMPC in employer contributions, the surplus, if any, is posted into the Dollar Bank (up to the Dollar Bank Ceiling), increasing your Dollar Bank reserve balance.

(a) **Actual Monthly Plan Cost.** The Board of Trustees calculates the AMPC of all Plan benefits: comprehensive family medical coverage, dental, vision, employee assistance program, life insurance and long-term disability benefits. The AMPC is a single composite rate reflecting the premiums charged by providers such as Kaiser, United Healthcare, Optum Rx and Delta Dental, as well as other related expenses of the Plan. It is this cost that is billed against each member's Dollar Bank on a monthly basis.

(b) **Dollar Bank Ceiling.** The Board of Trustees establishes the maximum reserve balance allowed in any single Dollar Bank. Any employer contributions made in excess of this amount will be credited to the general fund of the Trust, which supports the solvency of the Plan and helps Participants and their families.

2. **When Your Coverage Begins.** You must have accumulated to your credit a minimum number of hours of Covered Employment, depending on whether you are a Journeyman or Apprentice, within a continuous twelve-month period for which contributions have been made pursuant to the terms of a recognized collective bargaining agreement as defined in the Trust Agreement, or a Letter of Assent to such collective bargaining agreement. Coverage is to be effective on the first (1st) day of the second month after the month in which these eligibility requirements are satisfied. As an example, if you begin working in January and accumulate the required number of hours by the end of March, your coverage will become effective May 1st.

(a) **Minimum Hours for Initial Coverage for Journeymen.** You must have accumulated to your credit a minimum total of 300 hours of Covered Employment under the circumstances described above.

(b) **Minimum Hours for Initial Coverage for Apprentices.** Effective with December 1, 2008 hours, you must have accumulated to your credit a minimum total of 130 hours of Covered Employment under the circumstances described above. If you are an Apprentice who is attending day school through a recognized IBEW-NECA Joint Apprenticeship Training Committee, you must have a Dollar Bank balance of at least 80% of the AMPC for initial coverage.

3. **Initial Eligibility for Employees of Newly Signatory Employers.** Employees of newly signatory Employers who are employed and have worked a minimum of 130 hours in the month prior to the month in which the Employer begins to contribute to the Trust Fund may be eligible for benefits during the first month in which contributions are paid to the Plan, pursuant to the terms of a recognized collective bargaining agreement. The eligibility list must be received by the Plan Office by the third working day of the month and the contribution payment check by the tenth of the month during which the first contribution is due.

   Employees under this paragraph (Section II.A.3) will have up to three months from the first month that a newly signatory Employer begins contributing to the Plan to meet the minimum 130 hour per month work requirement, provided that all new employees are employed by the Employer as of the effective date of the Assent Letter under a recognized collective bargaining agreement.

4. **Continued Coverage.** The charge for coverage (after initial coverage has been established) shall be the AMPC against your Dollar Bank reserves, until an insufficient balance remains in your reserve. If you are an Apprentice who is attending day school through a recognized IBEW-NECA Joint Apprenticeship Training Committee, you must have a Dollar Bank balance of at least 80% of the AMPC for continued coverage. This reduced eligibility requirement for continued coverage is based on the percentage of time you are required to attend day school classes through the JATC. Hours worked in Covered Employment in one month shall not apply toward coverage in the next month, but in the second following month. (For example, if you work sufficient hours to receive contributions for work in June, those contributions, which are made by your Employer in July, are credited to your Dollar Bank for coverage in August.)

   If you elect to enroll in a Buy Up medical option, you will be required to pay the buy up amount, in addition to the AMPC.

5. **Industry Reciprocity.** In order to re-establish or preserve continuity of coverage in the Plan, you may apply for a transfer of contributions from a "Reciprocal Fund" — a health and welfare plan sponsored by a Local Union of the IBEW and chapter of NECA — in accordance with the Electrical Industry Health & Welfare Reciprocal Agreement ("Reciprocal Agreement"). To qualify, this Plan must be your "Home Fund" (the health and welfare plan to which contributions will be transferred and through which your health and welfare benefits will be covered), you must register on the Electronic Reciprocal Transfer System ("ERTS"), and you must present a valid photo identification at your Home Fund, the Participating Fund in which you have registered for work or an Assisting IBEW Local Union. You must agree both in writing and electronically (via ERTS) to (1) the legally binding effect of utilizing an electronic signature on ERTS and (2) an approved authorization and release regarding reciprocal transfers under the Reciprocal Agreement.

   You may designate this Plan as your Home Fund if you are a member of IBEW Local 595 and have been eligible for benefits under this Plan at any time during the past six years.

   You may designate this Plan as your Home Fund if you are a member of another IBEW Local Union that is party to the Reciprocal Agreement if:

   (a) you are currently eligible for benefits under this Plan,

   (b) you have not been eligible for benefits under your Local Union's Health and Welfare Plan at any time during the past six years, and

   (c) you establish your intent to return to work under the jurisdiction of this Plan as soon as work is available.

   The effective date of the transfer is the first day of the month in which you have properly registered on ERTS, provided you meet the eligibility requirements to claim the Plan as your Home Fund as described

above. Upon approval of the application based on the foregoing rules, the lesser of (1) contributions in an amount provided in the current Collective Bargaining Agreement of the Plan, or (2) contributions in an amount provided in the current Collective Bargaining Agreement of the Participating Fund in which you are working, will be transferred.

Reciprocity under this paragraph 5 will remain in effect unless, and until, you complete a "Request for Cessation of Transfer" on ERTS. For further information regarding the procedure, please contact the Plan Office.

The terms of the Reciprocal Agreement may be changed or amended from time to time by vote of the participating trusts throughout the United States. To determine whether changes have occurred in the Reciprocal Agreement since the printing of this booklet, contact the Plan Office.

6. **Loss of Coverage.** If you have not had eligibility under the Plan for a period of twelve consecutive months or more, your residual Dollar Bank balance (if less than a full AMPC) will be forfeited. Should you thereafter return to Covered Employment, you will have to re-establish eligibility as provided for in paragraph 2, above.

7. **Late Contributions.** On occasion, Employers fail to remit timely contributions to the Plan Office by the date on which the contributions are due. This results in the possible loss of eligibility for coverage for the employees of the delinquent Employer. However, in certain instances, late contributions may be applied toward the purchase of retroactive eligibility as set forth below.

(a) **Posting Date of Contributions.** When employer contributions are received by the Plan Office after the date on which the contributions were due, these late contributions are posted in the month that the hours were worked and not to the month in which the contributions are received by the Plan Office.

(b) **Retroactive Eligibility.** Where possible, late employer contributions are applied toward the purchase of coverage under the Plan in the same manner as though the contributions had been received when originally due. In other words, the late contributions are applied to a member's eligibility for coverage retroactively to the extent retroactive coverage is available.

For example, if you work sufficient hours in January to maintain eligibility for coverage under the Plan, the employer contribution is due in February, and if paid, coverage is purchased for March. If the Employer fails to submit a timely payment for contributions on your behalf in February, then you will lose eligibility for coverage in March, unless you otherwise qualify for continued coverage under the terms of the Plan or COBRA (as described in subparagraph (c), below) or are otherwise eligible for temporary extension of coverage under the 60-Day Protection Plan (as described in subparagraph (d), below). If, in April, the Employer remits payment on your behalf for contributions that were due in February (for the hours you worked in January), the Plan Office will post the late contributions to February for purposes of purchasing coverage for you retroactively for March. Therefore, if you incurred any Covered Expense in March, under the circumstances set out in this example, you may have a claim for reimbursement for those Covered Expenses under the Plan.

If, however, your Employer does not remit payment for the contributions that are due in February until the following October, retroactive coverage may not be available due to the length of time that has lapsed. The Board of Trustees does not determine whether retroactive coverage is available under an HMO or PPO; and availability for retroactive coverage is wholly dependent on the policy of the HMO or PPO program in which you are enrolled.

(c) **COBRA Continuation Coverage.** If you lose eligibility for coverage due to your Employer's failure to remit timely contributions to the Plan, and you have exhausted coverage resulting from your Dollar Bank reserves, Direct Self-Payments, Temporary Disability or the 60-Day Protection Plan, the Plan Office will notify you of your right to elect COBRA continuation coverage.

(i) **Enrolling in COBRA.** If you choose to enroll yourself and/or your Dependents in COBRA continuation coverage, you will be required to make timely payments to the Plan as described more fully in Section III.A., below. If your Employer belatedly remits payment for contributions on your behalf, said contributions may be used by the Plan to reimburse any source of funding used for continued coverage (e.g., your Dollar Bank reserves, Direct Self-Payments, COBRA payments or Service Corporation), but only for the month in which said contributions were due.

(ii) **Declining Enrollment.** However, if you choose not to enroll in COBRA upon loss of eligibility, in the event your delinquent Employer belatedly remits payment for contributions on your behalf, these late contributions will be posted to the month in which they were originally due, and used to purchase coverage retroactively for the month (to the extent retroactive coverage is available) that you had lost coverage due to the delinquency. You will not receive any reimbursement in connection with the late contribution.

(iii) **Other Coverage Options.** Coverage options other than COBRA may be available to you. You may, for example, obtain health coverage under an individual policy through the Health Insurance Marketplace, Medicaid or some other group health plan (such as a spouse's plan) through what is called a "special enrollment period." Any of these options may be less expensive than COBA and you may be eligible for premium tax credits and cost-sharing reductions that reduce your overall out-of-pocket cost. In general, however, if you elect COBRA, you will not be able to drop COBRA coverage and enroll through the Health Insurance Marketplace unless you are enrolling during the Marketplace's annual open enrollment period or one of the special enrollment rules applies.

(d) **60-Day Protection Plan.** (Note: Motor Shop, Maintenance and Subscription Agreement members are not eligible for this program.) This program is a health and welfare coverage benefit protection program funded by the Alameda County Electrical Industry Service Corporation ("Service Corporation"). It is intended to extend coverage for up to two months to Participants of the Plan who have lost eligibility due to their Employers' failure to make timely contributions to the Plan.

(i) In order to be eligible for this program, you must meet all of the following requirements:

(I) you are a Participant of the Plan;

(II) you have worked enough hours of Covered Employment within the jurisdiction of IBEW Local 595 in a month to maintain eligibility for coverage under the Plan;

(III) you do not have sufficient Dollar Bank reserves to maintain eligibility for coverage under the Plan for that month; and

(IV) due to your Employer's failure to pay (or failure to timely pay) contributions on your behalf, you will lose eligibility for coverage under the Plan.

(ii) If you meet all of the eligibility requirements listed above in clause (i) and either of the following two conditions is met:

(I) your Employer submits a monthly Employee Benefits Report ("EBR") but

(A) fails to submit an accompanying contribution payment for your hours of Covered Employment, or

(B) owes a late contribution payment to the Plan Office; OR

(II) your Employer submits neither an EBR nor any payment, but you can provide documentation of your work for the Employer by virtue of pay stubs issued by that Employer; (note: if this situation applies to you, it is your obligation to submit pay stub documentation to your Local Union), you will be entitled to one month of health and welfare coverage for the month for which contributions should have been made by your Employer but were not. If, in the following month, your Employer submits an EBR but is delinquent with the payment again, and you meet the eligibility requirements under this program, the Plan Office will extend health and welfare coverage for a second and final month. After this final month of extended coverage, your coverage will be terminated and the Plan Office will issue you a COBRA Notice.

The Service Corporation will be reimbursed if the Employer later submits payment after a Participant receives any portion of the 60-Day Protection Plan benefit.

B. IF YOU ARE A RETIREE MEMBER

(Note: Does not apply to Local 595 Motor Shop Participants.)

1. Regular Retirees. If you have attained at least age 62 and retire from work in the Electrical Industry as defined in Section II.B.11 below, you will qualify for enrollment as a Retiree member provided you:

(a) have been covered as an Active member and/or pursuant to a Full AMPC payment under a Master Subscription Agreement for hours equal to 120 months out of the last 180 months and 24 months out of the last 60 months immediately preceding age 62 or subsequent retirement age; or

(b) have been eligible for Active coverage, but with less than ten (10) years of participation provided you:

(i) have had continuous coverage under the Plan since the inception date of your work in the Electrical Industry, and

(ii) qualify for retirement and have retired under the IBEW Local 595 Pension Plan.

2. Alternate Eligibility Rules for Retirees. In the event you have attained age 62 but are unable to qualify for enrollment as a Retiree member based upon the eligibility rules set forth in Section II.B.1 above, you shall be eligible for Retiree coverage if you:

(a) had Active coverage eligibility for at least 300 months;

(b) have been covered as an Active member and/or pursuant to a Full AMPC payment under a Master Subscription Agreement for hours equal to 24 months out of the last 60 months; and

(c) qualify for retirement and have retired under the IBEW Local 595 Pension Plan.

NOTE: Participation as an Active member includes participation in the Electrical Workers Area Health & Welfare Plan, which terminated February 1, 1998. A Retiree's Home Plan is the successor plan to the Area Retiree Health & Welfare Plan, sponsored by the Local Union and NECA chapter in whose jurisdiction the majority of Active coverage contributions were made on his or her behalf. For example, if a Retiree has 10 years of Active coverage, but only four (4) of those were through the Local 595 Trust and six (6) were through the Local 6 Trust, Retiree coverage will be not be provided by the Local 595 Trust. This note applies to Locals 413, 639, 595 and 6 only.

3. **Disabled Retirees.** If you are a member under age 62 and become totally disabled, as defined below, while Active coverage is in force, you will qualify for enrollment as a Disabled Retiree provided you:

(a) Have ten (10) years or more of participation in the Plan; and

(i) have been covered as an Active member and/or pursuant to a Full AMPC payment under a Master Subscription Agreement for hours equal to 120 months out of the last 180 months and 24 months out of the last 60 months, immediately preceding disability; and

(ii) you have exhausted your Dollar Bank reserves, or temporary disability coverage; OR

(b) Have less than ten (10) years of participation; and

(i) have had continuous Active member coverage since the inception of your work experience in the Electrical Industry as defined in Section II.B.11, below, and qualify for retirement and have retired under the IBEW Local 595 Pension Plan; or

(ii) were, at the time of disability, a currently enrolled apprentice, and have exhausted temporary disability coverage available as an Active member.

(c) In addition to satisfying either subparagraph (a) or (b), above, you must submit proof of total and permanent disability to the Plan Office and an application for disability retirement within ninety (90) days of the date you are awarded a permanent Social Security Disability Benefit under Title II of the Social Security Act (see below).

"Total and Permanent Disability" means that you are unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment which has lasted or can be expected to last for a continuous period of at least twelve months, or can be expected to result in death. The impairment must be so severe as to prevent you not only from engaging in your usual work, but also, considering your age, education, previous training and work experience, from engaging in any substantial gainful work which exists in significant numbers in the region in which you live.

You must be under the care of a legally qualified Physician and have been awarded a permanent Social Security Disability Benefit under Title II of the Social Security Act. Proof that you continue to qualify for Social Security Disability Benefits will be required at reasonable intervals by the Plan. If you fail to furnish proof, or if you refuse to be examined by a Physician (designated and paid for by the Trust), you will no longer be considered totally and permanently disabled. (See also Section III.B.3, Temporary Disability Coverage.)

4. **Early Retirees.** Subject to the following provisions, a member who retires may maintain coverage in the Plan as an Early Retiree.

(a) **Service Requirements.** You must satisfy the service requirements for Regular Retiree membership status as set forth in Section II.B.1 above, but with respect to your retirement age rather than age 62.

(b) **Minimum Age Requirement.** You must have attained at least age 55.

(c) **Retirement.** You must have retired under the IBEW Local 595 Pension Plan.

(d) **Payment Obligation.** You must make continuous early retirement self-payments at the rate determined by the Board of Trustees to maintain coverage under this Plan.

Self-payments for coverage must commence with the first (1st) of the month following retirement and exhaustion of your Dollar Bank reserves and are due by the tenth (10th) of the month preceding the month for which coverage is to be provided. Failure to make timely payments will result in the cancellation of Early Retiree coverage without right of reinstatement. In addition, self-payments for Retiree coverage are to resume upon your becoming eligible for Medicare.

(e) **Death of an Early Retiree.** If you have maintained coverage as an Early Retiree, but die prior to qualifying for Regular Retiree status at age 62 or age 65, your eligible surviving Dependents will qualify for Retiree coverage on the first (1st) day of the month following the date of death.

5. When Retiree Coverage Begins.

(a) **Coverage for Retirees.** If you meet all of the requirements to qualify for Retiree coverage, you will become eligible for Retiree coverage effective on the first (1st) of the month following submission of a completed application for enrollment, or upon exhaustion of any Temporary Disability Coverage or Dollar Bank reserve, whichever occurs later. (See Section III.B.3 for Temporary Disability Coverage.) If you exercise your one-time option to purchase health coverage outside the Plan, the effective date of your Retiree coverage is the date you make this election.

(b) **Coverage for Dependents.** Coverage for your Dependents (as defined in Section II.C), will become effective on the later of the following dates:

(i) the date you become eligible for Retiree coverage, or

(ii) the first (1st) of the month after you acquire a Dependent, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

6. Cost of Retiree Coverage. The Plan may charge Retirees and surviving spouses/Domestic Partners a monthly charge. The Board of Trustees has the discretion to fix and to change the amounts of the monthly charge based on the cost of coverage to the Plan. Information about the current rates may be obtained from the Plan Office.

7. Enrolling in Medicare. You and your Dependents are required to enroll in Medicare Parts A and B upon becoming eligible for these programs. If you and/or your Dependent fail to enroll in these Medicare programs, you will not receive coverage under the Plan.

Medicare is our country's health insurance program for people age 65 or older, certain people with disabilities who are under age 65, and people of any ages who have permanent kidney failure. If you are receiving Social Security Disability Income ("SSDI") benefits, you generally become eligible for Medicare coverage 29 months after your SSDI date of disability determination.

There are two parts to Medicare that relate to hospital and medical insurance. They are hospital insurance (Medicare Part A) and medical insurance such as for the cost of Physicians (Medicare Part B). Medicare Part A is financed by payroll taxes; and, if you are eligible to receive it based on your own — or your spouse's — employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by those who choose to enroll. For enrollment and eligibility information, call Social Security at 1-800-772-1213. You can also find Medicare information on the Internet at www.medicare.gov.

The Plan, through its providers (i.e., United Healthcare or Kaiser), offsets expenses for services or supplies to the extent they are or may be payable under Medicare. The difference between the premiums charged to the Plan and the premium for the Medicare Risk Program will be billed back to you if you and/or your Dependent fails to enroll in the Medicare Risk Program.

Therefore, once you or your Dependent becomes eligible to enroll in Medicare, the Plan's providers will process any eligible claims incurred on or after that date as though Plan coverage is supplementary to Medicare coverage, even if you or your Dependent fails to enroll. If you or your Dependents are eligible to enroll in Medicare and have selected one of the Plan's HMOs, you and/or your Dependents must enroll in that HMO's Medicare Risk Program, if available, provided you reside within the HMO's Medicare Risk service area.

Medicare Part D is addressed in Section II.D.4 and Section IV.B.1.

8. **One-Time Opt Out.** As a Retiree, you and/or your Dependents may exercise a one-time option to directly purchase health coverage outside the Plan without jeopardizing your eligibility for Regular Retiree coverage. If you choose to suspend payments while covered under another plan, you will be permitted to enroll in this Plan by making self-payments for Retiree coverage, provided you and/or your Dependents submit proof of continuous "minimum essential coverage," as defined by the Affordable Care Act, during the opt-out period immediately prior to enrollment. No greater than the most recent 12 months of continuous coverage will be required. (See https://www.healthcare.gov/fees/plans-that-count-as-coverage/ for information about what type of coverage constitutes minimum essential coverage.

9. **Suspension of Retiree Benefits.**

(a) **General Rule.** If you are eligible for Retiree coverage, your eligibility for such coverage will be suspended during any period you return to Active employment in work of the type performed by members covered by the Plan, provided such work:

(i) requires directly, or indirectly, the use of the same or similar skills previously employed by such member; or

(ii) may be directly or indirectly applicable to the performance of any occupation in the industry such as selling, retailing, management, supervisory, clerical, or professional; within the State of California.

If you are eligible for Retiree benefits under the Plan and return to Active employment not resulting in a termination or suspension of benefits, benefits under the Plan shall be coordinated as described under the "Coordination of Benefits" rules in Section VII.

(b) **Retiree Coverage Continued for Limited Time.** If you are eligible for Retiree benefits under the Plan and return to Active employment pursuant to a collective bargaining agreement requiring contributions on your behalf to establish eligibility for coverage under the Plan, suspension of Retiree benefits shall commence upon the date your eligibility as an Active member is re-established or upon the first (1st) of the third month following the date of your return to Covered Employment, whichever occurs first.

(c) **Reinstatement Rule.** If you are suspended under this paragraph 9, upon notification to the Plan Office that such occupation has ceased, Retiree benefits shall be reinstated no later than the first (1st) of the month following the depletion of your Dollar Bank.

(d) **Forfeiture Rule.** If you are an Early Retiree, you must refrain from engaging in work in the Electrical Industry unless you return to work for a Contributing Employer.

(i) **Return to Non-Contributory Employment in the Electrical Industry.** A return to work for a Non-Contributory Employer shall result in cancellation of your coverage under the Plan without right of reinstatement, and you will be obligated to reimburse the Plan for any benefits paid on your or your family's behalf during any period of such employment.

(ii) **Return to Contributory Employment in the Electrical Industry.** If you return to Covered Employment under the Plan and subsequently become eligible for coverage as an Active member based on your work hours, you will not be required to continue making Early Retiree self-payments. Upon subsequent retirement prior to age 62, you will be required to make continuous Early Retiree self-payments until you qualify for Regular Retiree coverage under Paragraph 1.

10. **Annual Verification of Retiree and/or Dependent Eligibility for Benefits.** In order for you or your Dependent to maintain eligibility for Retiree benefits under the Plan, you must complete and submit a Verification of Eligibility form to the Plan Office once a year. The Plan Office will mail this to all enrolled Retirees annually at a time designated by the Board of Trustees.

11. **Definitions.** For purposes of meeting the requirements of this subsection, the following definition applies:

"Work in the Electrical Industry" means work experience in any private or public employment in the electrical industry in the United States or Canada.

12. **Dollar Bank Residual Forfeiture Upon Retirement.** Upon your retirement any residual Dollar Bank balances that are less than a Full AMPC that remain unused for a twelve-month period during which no Dollar Bank contributions are made will be forfeited upon a participant's retirement under the Plan, except if you have elected to exercise the one-time opt-out option.

C. IF YOU ARE A DEPENDENT

1. **Definition of Dependent.** "Dependent" means your lawful spouse, your Domestic Partner as defined below, or a Child under 26 years of age.

(a) **Child.** "Child" includes your natural child, stepchild, legally adopted child, foster child or other child provided such child is dependent upon you for support and maintenance and is part of your household (this includes the child(ren) of your Domestic Partner) or a child for whom you have been appointed legal guardian or are required to provide dependent coverage pursuant to a Qualified Medical Child Support Order ("QMCSO"). The Plan Office must be furnished a copy of a court order for any child who has been appointed to the care of a member pursuant to a court-ordered Guardianship of the Person. A copy of the Plan's Qualified Medical Child Support Order procedures may be obtained from the Plan Office without charge.

(b) **Domestic Partner.** "Domestic Partner" is defined as a spousal equivalent relationship sanctioned by the laws of a state, county, city or other municipality. Domestic Partners shall become eligible on the first day of the month following the month the Plan Office receives proof of Domestic Partner status in the form of an official certification of registration of Domestic Partnership and an affidavit of "dependency" for tax purposes. The Plan will not be responsible for any taxes, tax related penalties or interest imposed on the member as a result of providing Domestic Partner coverage.

2. **Eligibility for Your Disabled Dependent Child Age 26 or Older.** Your Dependent Child covered under the Plan whose coverage would otherwise terminate solely due to attainment of the limiting age shall continue to be considered a Dependent under the Plan while he or she is incapable of self-sustaining employment by reason of mental or physical disability, provided written evidence of such incapacity is furnished to the Plan Office with respect to that Child by the earlier of: (a) the thirty-first day after the Child's attainment of such age 26; or (b) the thirty-first day after you receive notification of the incapacity of such Dependent Child. The Child must have the same primary residence as you and must receive at least 50% of his or her financial support from you to be considered a Dependent under the Plan. Proof of the continued existence of such incapacity and the other requirements listed above must be furnished to the Plan Office from time to time at the Plan's request.

3. **Coverage for Your Dependent if You Die.** Upon your death, your surviving spouse and Dependents will be eligible for benefits until your Dollar Bank reserve is exhausted. Thereafter, if you died while you were an Active member, your surviving Dependents will be eligible for Retiree coverage if, regardless of

your age at the date of death, you would have met the Retiree membership eligibility set forth in Section II.B. If you died while you were a Retiree, your Dependents will remain eligible for Retiree member Dependent coverage in the Plan upon your death. If your surviving spouse or Dependent declines coverage at the time of death because he or she has coverage under another health plan, that individual may enroll in the Plan at a later date, if requested within thirty (30) days after that other coverage ends.

Otherwise, your Dependents are eligible for enrollment in COBRA. If you have no Dependents at the time of your death, your successors shall have no claim for coverage, payments, or refunds. Life insurance benefits shall be subject to the "Termination of Individual Insurance" clause in the Group Life Insurance policy.

In all cases, surviving spouse/Domestic Partner coverage will cease upon a remarriage/re-registration.

D. ENROLLING IN YOUR BENEFITS

1. **Benefit Program Selection.** Under the Plan, you may select among various benefit options, including an indemnity option (Actives and Non-Medicare Retirees only) and two HMOs. Refer to Section IV.A.2 for general information concerning HMOs that are available under the Plan.

As of the date of the publication of this SPD, the Plan's "Base" medical plan is Kaiser HMO. (Please check with the Plan Office for the current base medical plan.) The Plan also offers a Buy Up option that would allow you to enroll in a different plan option other than the Base plan. These are United Healthcare and Self-Funded Indemnity Plan options. To enroll, you must buy up to these plan options by paying the monthly buy up amount by authorizing automatic deductions from your Health Reimbursement Account Plan ("HRA") each month. If there are insufficient funds in your HRA you must make direct payment of the buy up amount before each month begins. The buy up cannot be paid out of your Dollar Bank reserve.

If you are an Active or Non-Medicare Retiree member and do not select either the Base plan or a Buy Up option, you will automatically be enrolled in the Additional Deductible Indemnity Medical Plan. (See Additional Deductible Indemnity Medical Plan, Section IV.A.1.)

2. **Rolling Enrollment.** You will be given the opportunity to change your benefit program selection one time in a 12-month period. The Plan will provide enrollment material with program information at the time of your enrollment or upon your request. **All of your Dependents are covered in the same option that you choose for yourself, if they are properly enrolled in the Plan. No benefits are payable for any person who is not properly enrolled. The Board of Trustees has the discretion to change or establish other enrollment periods.**

3. **Special Enrollment.** Because Plan benefits are available to you without cost, you will ordinarily want to enroll in the Plan, along with Dependents. However, for various reasons, you may wish to decline enrollment for an otherwise eligible family member (e.g., to avoid taxable income for covering persons who do not meet the definition of dependent under the Internal Revenue Code). If you fail or decline enrollment for any eligible individual who has other health insurance coverage, you may later enroll that individual in the Plan if you request enrollment within 30 days after that other coverage ends. Also, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents if you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

In addition, if you or your Dependents were covered under a Medicaid plan under Title XIX of the Social Security Act or under a State Children's Health Insurance Program ("CHIP") and you (or your Dependent's) coverage is terminated as a result of loss of eligibility for such coverage or you (or your Dependent) becomes eligible for premium assistance with respect to coverage under the Welfare Plan

under a Medicaid plan or CHIP, you may be able to enroll yourself and your Dependents provided that you request enrollment within 60 days after the occurrence of such events.

4. **Medicare Part D.** If you are a Medicare-eligible Retiree and choose to enroll with an outside Medicare Part D provider (covering prescription drugs) you will automatically be disenrolled from this Plan.

5. **Enrollment Form.** If you are an Active member, you are required to complete an enrollment form and must, in order to cover your Dependents, include copies of marriage certificates or Domestic Partner registration certificates, where appropriate, and birth certificates for Dependents. Verification may be requested by the Trust at reasonable intervals.

6. **Effective Date of Eligibility.** All members and their Dependents who qualify under the eligibility provisions of this booklet shall be covered effective 12:01 a.m. of the first day on which they qualify.

E. WHEN YOUR COVERAGE ENDS

You or your Dependent's coverage will terminate at the end of the month upon the occurrence of any of the following events:

1. the date of the termination of the Plan;

2. the date your status as a Participant, Dependent, or beneficiary terminates;

3. the date your Dependent is disenrolled from coverage under the Plan;

4. the date you fail to make any required self-payments under the Plan;

5. the date you have insufficient Dollar Bank reserves for coverage under the Plan;

6. the date the Plan is modified to terminate one or more benefits;

7. the date of the termination of total disability prior to age 62;

8. with respect to Retirees, the cessation for six (6) consecutive months of any required self-payments which may be established by this Plan. Reinstatement may be effected within the six (6) consecutive months provided all required payments necessary to assure continuous coverage are paid in full;

9. with respect to Dependent spouses, the date your divorce decree is final;

10. with respect to Dependent Domestic Partners, the date your Domestic Partnership is dissolved;

11. with respect to surviving spouses or surviving Domestic Partners, the date of remarriage/ re-registration;

12. the date you or your Dependent materially misrepresent information provided to the Plan or commit fraud or forgery in connection with receipt of Plan benefits; or

13. the date you or your Dependent allow a non-eligible person to obtain or attempt to obtain benefits from the Plan.

III. CONTINUATION OF COVERAGE

A. COBRA CONTINUATION COVERAGE

1. **Quick Reference.** Under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), you and your covered Dependents (Qualified Beneficiaries) may continue health care coverage past the date coverage would normally end under certain circumstances (Qualifying Events). You and your covered Dependents will be required to pay the full cost of the coverage plus two percent for administration in order for your coverage to be continued.

A Qualified Beneficiary as defined under COBRA means any individual who on the day before a Qualifying Event was covered under this Plan by virtue of being, on that day, either the Employee, the spouse of an Employee or Retiree, or a Dependent Child of an Employee or Retiree. A Child born to or placed for adoption with an Employee or Retiree during a period of COBRA Continuation Coverage shall be a Qualified Beneficiary entitled to his or her own COBRA rights. Circumstances under which health care coverage can be continued and the duration of Continuation Coverage are outlined in the following chart. Refer to the following pages for a complete description of COBRA Continuation of Coverage Provisions.

This Plan will treat Domestic Partners as defined in Section II.C.1., above, as spouses for all COBRA purposes under the Plan.

QUALIFYING EVENT	QUALIFIED BENEFICIARY	MAXIMUM CONTINUATION PERIOD
Termination of employment except for gross misconduct; or Reduction in hours resulting in a loss of eligibility	Member, Spouse and/or Dependent Child(ren)	18 months after date of losing coverage
Death of Member	Spouse and/or Dependent Child(ren)	36 months after date of qualifying event
Divorce of Member	Divorced spouse	36 months after date of qualifying event
Dependent ceases to be eligible under the terms of the Plan	Affected Dependent	36 months after date of qualifying event
Member's entitlement to Medicare: (1) prior to an initial qualifying event (2) second qualifying event	Spouse and Dependent Child(ren)	(1) Later of 18 months from the qualifying event or 36 months from the date of the employee's Medicare entitlement (2) 36 months after date of initial qualifying event
Second Qualifying Event	Member, Spouse and/or Dependent Child(ren)	Coverage may be extended for a second qualifying event occurring during the initial 18-month period; provided that the aggregate period of continuation coverage does not exceed 36 months.

(a) **What is COBRA Continuation Coverage?** You and your spouse and Dependent Child(ren) (also referred to as "Qualified Beneficiaries") have the right to continue coverage under the Plan for a period of time defined by federal law if eligibility terminates due to certain events. These events are called "Qualifying Events." This Continuation Coverage may require self-payment of premiums and does not include life insurance or accidental death and dismemberment benefits. You may select "core" coverage, which provides medical and prescription drug benefits only, or "core plus," which includes medical, prescription drug, dental and vision benefits. In addition, Qualified Beneficiaries are allowed to make the same choices given to non-COBRA beneficiaries under the plan, such as during periods of rolling enrollment by the plan.

(b) **If You Are an Active Employee.** If you are an Active Employee, you may continue your coverage if one of the following Qualifying Events occurs: (a) your employment terminates for any reason except gross misconduct; or (b) you lose eligibility because the contributions from a Contributing Employer are not sufficient to continue your eligibility, and you have exhausted coverage resulting from Direct Self-Payments and/or Temporary Disability (as described in Sections III.B.2 and III.B.3 respectively, below).

(c) **If You Are the Spouse/Domestic Partner of an Active Employee or Retiree.** Your spouse/Domestic Partner may continue coverage if you die or you and s/he divorce or become legally separated. A spouse/Domestic Partner of an Active Employee may also continue coverage if: (a) your employment terminates for any reason except gross misconduct; or (b) you lose eligibility because the contributions from a Contributing Employer are not sufficient to continue your eligibility, and you have exhausted coverage resulting from Direct Self-Payment and/or Temporary Disability Coverage (as described in Sections III.B.2 and III.B.3, respectively, below).

(d) **If You Are a Dependent Child(ren) of an Active Employee or Retiree.** Your Dependent Child(ren) may continue coverage if one of the following qualifying events occurs: s/he ceases to be a Dependent as defined in Section II.C.1; you die; or you and your spouse divorce or become legally separated. Dependent Child(ren) of an Active Employee may also continue coverage if: (a) your employment terminates for any reason except gross misconduct; or (b) you lose eligibility because the contributions from a Contributing Employer are not sufficient to continue your eligibility, and you have exhausted coverage resulting from Direct Self-Payment and/or Temporary Disability Coverage.

New Dependents acquired while you are covered under COBRA can be added by notifying the Plan Office within 60 days of acquiring the new Dependent.

2. **Length of Continuation Coverage.** Coverage may continue, on a self-pay basis, as follows:

(a) **If you are an Active Employee,** coverage for you and/or your Dependent(s) may be continued for up to 18 months if coverage is terminated due to your termination of employment (other than for gross misconduct), or reduced days of employment.

If the Social Security Administration determines that you or any of your covered Dependents were disabled during the first 60 days of COBRA Continuation Coverage and you inform the Plan Office before the end of the 18-month continuation period, coverage may be extended for an additional 11 months, for a total of 29 months.

Proof of disability must be provided to the Plan Office within 60 days of the date the Social Security Administration makes the determination. This extended period of Continuation Coverage applies to the person who has been determined to be disabled by the Social Security Administration (and/or any other family members if family coverage is elected).

(b) **If you are either an Active Employee or Retiree,** Dependent coverage may be continued for up to 36 months, if coverage is terminated due to your death, divorce, or legal separation, or your Dependent Child's ceasing to satisfy the Plan's definition of a Dependent.

If Active Dependent coverage is continued after termination of your employment or reduction in hours worked and, during the Initial Continuation Period, a second Qualifying Event occurs which entitles the Dependent to Continuation Coverage, your Dependent may elect to continue coverage up to a combined maximum of 36 months. Dependents will include your newborn and adopted Children added after the qualifying event, provided the Dependent is enrolled within 60 days after the birth or placement for adoption. A Child born or placed for adoption while COBRA coverage is in effect will have all the same COBRA rights as your Dependents who were covered by the Plan before the qualifying event that resulted in your loss of coverage.

3. **Cost of Continuation Coverage.** You and/or your Dependents are responsible for all premium payments for Continuation Coverage. As allowed by federal law, the premium payment will be equal to the cost of the coverage selected plus 2% for administration. The cost to continue coverage under the disability portion of COBRA will be equal to 150% of the cost of coverage selected plus 2% for administration. The COBRA rates are calculated once each year effective February 1st.

4. **No Coverage During Election Period.** A Qualified Beneficiary will not be covered for Plan benefits during the 60-day election period and the 45-day period allowed to **pay for** COBRA coverage. However, if a COBRA coverage election is made in accordance with the current COBRA laws and all applicable premiums are paid in a timely manner, then coverage through the Plan for the coverages selected will be retroactive to the original loss of coverage date in accordance with federal law. If a medical, dental or vision provider calls for verification of eligibility or benefits during the election period and the Plan Office does not have a record of a timely and properly completed election form and payment of premium, the provider will be told that the Qualified Beneficiary does not have coverage but that he/she will be covered as of the COBRA effective date provided that a timely and properly completed election form and premium payment are received. Upon timely receipt of a properly completed election form and payment of all applicable premiums, COBRA continuation coverage shall be in effect.

5. **Notice Requirements.** If your Dependents would lose coverage due to your divorce or legal separation from your spouse or your child ceasing to be a Dependent, you or your Dependent must notify the Plan Office within the later of 60 days of (a) the event or (b) the date coverage would be lost as a result of the event. **If the Plan Office is not notified within the 60-day time limit, your Dependent(s) will lose the right to elect COBRA.**

   If coverage would be lost due to your death, termination of employment or insufficient hours worked, your Employer must notify the Plan Office. However, it is advisable that you or your Dependents provide notification as well. The Plan Office will advise you of the cost of COBRA when it sends you the COBRA notice. The election of COBRA rights must be made in writing within 60 days of the later of (1) the date the notice is sent to you or (2) the date your regular Plan coverage terminates. You must pay the required premium within 45 days of the election. If you reject COBRA Continuation Coverage, your spouse and Dependent Children may elect coverage within the 60-day period.

6. **When Continuation Coverage Ends.** The continued coverage will cease on the first of the following dates:

   (a) the date the Plan terminates;

   (b) the date a required COBRA premium is due and unpaid. A delinquency occurs if:

      (i) Initial payment is not made within forty-five (45) days after the date the application for COBRA continuation coverage is received in the Plan Office; or

      (ii) A subsequent monthly payment is not made within thirty (30) days of the due date set by the Plan Office.

   (c) the date you and/or your Dependent(s) become insured under another group health plan. This may not apply if you or your Dependent has a pre-existing condition, which is not covered under the new plan. Contact the Plan Office for additional information when you and/or your Dependents become insured under another group plan;

   (d) the date the applicable period of continuation is exhausted;

   (e) the date the Employer who contributed on behalf of the eligible member ceases to be a Contributing Employer;

(f) the date an individual on COBRA extension becomes eligible for Medicare;

(g) the first (1st) day of the month which begins 30 days after you or your Dependent(s) receive a final determination from Social Security that you or your Dependent(s) are no longer disabled. (Applies in situations where the Qualifying Event was termination of employment or reduction in hours and where COBRA coverage was being continued for an additional 11 months.)

7. **Available Coverage Options.** Each individual eligible for COBRA extension may elect either Core Coverage only or both Core Coverage+Non-Core Coverage. "Core" Coverage is medical coverage only. "Non-Core" Coverage is dental and vision care coverage where applicable. If Core+Non-Core Coverage is elected, then all Non-Core Coverage will be included — an individual may not elect dental only or vision only if both coverages are available.

Full details of COBRA Continuation Coverage will be provided to you or your Dependents when a Qualifying Event occurs.

B. NON-COBRA CONTINUATION OF COVERAGE

The following alternative non-COBRA coverage may be available to you and/or your Dependents under the Plan.

1. **Gap Payment.** For months where the employer contributions and your Dollar Bank reserves do not cover the AMPC, if your dollar Bank reserve is at least 50% of the AMPC, you may make a "gap" payment to bring your Dollar Bank reserve up to the level of the AMPC and continue coverage of benefits under the Plan.

2. **Direct Self-Payment.** If you are already covered under the Plan, but your accumulated employer contributions have fallen below the AMPC, you may, in order to maintain continuous coverage, make payments directly to the Plan under the following conditions,

(a) **Loss of Coverage.** Loss of coverage (due to termination, reduced work hours or exhaustion of COBRA) must have occurred on or after June 1, 2010.

(b) **12-Month Eligibility Requirement.** You have acquired twelve months of eligibility under the Plan within the last twenty-four months (based on employer contributions, Dollar Bank reserves or self-payments or COBRA).

(c) **Availability for Employment; Exceptions.** You must be actively seeking employment on the IBEW Local 595 Available for Work List. There are two exceptions:

(i) if you are disabled and unable to work, and present a Doctor's certificate (from an "acceptable medical source," as defined by the regulations governing the Social Security Administration, e.g., M.D., D.O.) reflecting your disabling condition and inability to work to the Plan Office; or

(ii) if you obtain written approval from the Board of Trustees to make direct self-payments during an extended leave of absence, subject to the time limits outlined in paragraph 3 below.

(d) **Amount.** Self-payments for Active Participants are charged at 50% of the AMPC, set by the Board of Trustees. The Self-Pay rate is based on the Base Medical Plan.

A Participant who wants to enroll in a plan option other than the Base Plan must pay the buy up amount each month.

(e) **No Break in Payments.** There may not be a break in payments, and all payments must be received by the Trust or Affiliated Trust Office by the 20th of the month prior to the month for

which coverage is to be effective or the date established by your Board, whichever is earlier; provided, however, that the first such payment shall be accepted if remitted within 20 days of the date you are notified of loss of coverage.

(f) **Maximum Period of Direct Self-Payment.** So long as you continue to qualify for continued coverage by direct self-payments, such payments may continue up to a maximum of 6 months in a 24-month period, provided that if at any time during the 6 months you are disabled and unable to work, and present a Doctor's certificate reflecting your disabling condition and inability to work, you may qualify for up to 6 months of temporary disability coverage as described in Temporary Disability Coverage in paragraph 3 below. However, in no event may the combination of direct self-payment coverage and/or temporary disability coverage exceed a total of 12 months for any single continuous period of disability as defined below. All periods of direct self-payments (other than the period in which payments are made for COBRA continuation coverage) will be included for purposes of determining eligibility for Retiree coverage.

3. Temporary Disability Coverage.

(a) **Applying for Coverage.** If you become temporarily disabled while Active coverage is in force (excluding coverage through COBRA payments) and request that you be placed on the Temporarily Disabled List, you are eligible for coverage provided that you meet all of the following requirements:

(i) you are unable to perform the duties of your regular occupation covered under an IBEW Collective Bargaining Agreement;

(ii) your disability continues for a period of thirty (30) days; and

(iii) you submit proof to the Plan Office that you qualify for and are receiving California State Disability Insurance ("SDI") benefits. Note: in order to avoid a gap in coverage while you are waiting for qualification and receipt of SDI benefits, you may provide the Plan Office certification of your disability from your attending Physician along with a copy of your application for SDI benefits for immediate coverage up to one month.)

(b) **Coverage Period.** If the evidence you submitted is satisfactory to the Board of Trustees, you shall, upon exhaustion of the funds in your Dollar Bank reserve, if any, have your Plan coverage extended without charge while you are disabled for a period not to exceed 6 months in a 24-month period, provided that you have acquired twelve months of eligibility within the last twenty-four months. You may then make direct self-payments, but in no event shall the combination of temporary disability coverage and coverage resulting from the direct payment provision in paragraph 2 above, exceed a total of 12 months of coverage for any single continuous period of disability.

(c) **Limited 3-Month Extension.** Temporary disability coverage will be extended for up to three (3) months following the month of your recovery, provided you have returned to Covered Employment, in order to allow you to accumulate the necessary hours to re-qualify for eligibility under the Plan, provided such extended eligibility does not exceed the above maximum of 12 months per a single continuous period of disability.

(d) **Subsequent Retiree Coverage.** In the event Temporary Disability Coverage has continued for the maximum period, you may qualify for Retiree coverage if you meet all of the requirements set forth in Section II.B.3, Disabled Retirees. All periods of temporary disability coverage will be counted for purposes of determining eligibility for Retiree coverage (applies to Local 595 members only).

4. Continuation Coverage Under the Family and Medical Leave Act. The Family and Medical Leave Act of 1993 ("FMLA") provides that in certain situations you are entitled to take a specified amount of unpaid leave, and that in such situations the Contributing Employer is required to continue coverage for you. Determination as to whether a leave of absence is an FMLA leave shall be made by the Contributing Employer, and is subject to review by the Board of Trustees. If such a leave is requested, you must submit proof acceptable to the Plan that the leave is in accordance with FMLA provisions.

(a) Eligibility for FMLA Leave. To qualify for continuing coverage under FMLA, you must be employed by a Contributing Employer with 50 or more total employees within 75 miles from your work site, or the Contributing Employer is a public agency; and you worked for your Contributing Employer for at least 12 months; and you worked at least 1,250 hours during the 12-month period preceding the start of the FMLA leave of absence; and you are on an FMLA-qualified leave from employment with the Contributing Employer; and one of the circumstances described below in (i)-(iii) apply.

(i) Newborn/Adopted Child; Family Member with Serious Health Condition; Your Own Serious Health Condition. The FMLA may entitle you to continuing coverage when you take leave to care for or bonding with a newborn child or for placement of an adopted child; to care for an immediate family member with a serious health condition; and because of your own serious health condition.

(ii) Member of Your Family Called to Active Duty. You may be entitled to continuing coverage if a member of your immediate family is a member of the National Guard or Reserve and is called to active duty, you may have continued coverage under the Plan if your leave from work is due to the active duty or call to duty, and relates to one of the following: (1) short-notice deployment; (2) military events; (3) childcare and school activities; (4) financial and legal arrangements; (5) counseling; (6) rest and recuperation; (7) post-deployment activities; and (8) other events that arise from the military member's active duty or call to duty.

(iii) Military Caregiver Leave. You may be entitled to continuing coverage if a member of your family is a member of the Armed Services, National Guard or Reserve, and suffers a serious injury or illness that is incurred in the line of duty on active duty.

(b) Maximum Leave. For circumstances described in Sections III.B.4(a)(i) and Sections III.B.4(a)(ii) above, you may be entitled to take up to 12 weeks of unpaid leave during any 12-month period. In the event that both you and your spouse are covered Employees, under most circumstances, the FMLA continued coverage may not exceed a combined total of 12 weeks if the FMLA leave is related to the birth or placement of a child or to caring for a parent with a serious health condition. If you are on a FMLA leave on the day coverage is to begin, coverage will nonetheless begin.

(c) End of Leave Period. Continuation of coverage under FMLA ends on the earliest of: (i) the day you return to work; (ii) the day you notify your Employer that you are not returning to work; (iii) the day coverage under the Plan would otherwise end (i.e., Plan maximum has been paid); or (iv) the day after coverage has been continued under FMLA for the maximum leave period allowed.

(d) Effect on Your Dollar Bank and Employer Contributions. In addition, if you are currently working in Covered Employment and exercise a right to Family Medical Leave:

(i) any funds in your Dollar Bank shall be frozen as of the last day of the month in which the leave begins;

(ii) your then-current Employer shall be responsible to continue remitting payment to the Plan Office, Employer contributions for the actual hours worked or 50% of the AMPC, whichever is greater, until the maximum statutory leave period expires or your return to Covered Employment (which shall include registration at the Union's referral office), whichever occurs first.

(iii) funds in your Dollar Bank (if any) shall be unfrozen on the first (1st) of the month immediately following the month in which you return from leave (which includes registration at the Union's referral office) or the statutory period of subsidized leave terminates, whichever occurs first.

(iv) Upon termination of leave benefits, you shall not lose membership status and may exercise any coverage continuation program available generally to members of the Plan, including self-payments, disability extension and COBRA.

You should contact your Employer to find out more about Family and Medical Leave and the terms under which you may be entitled to it. If there is any conflict between these provisions and FMLA, the minimum FMLA provisions shall govern.

5. Continuation Coverage While in Uniformed Service.

(a) **Who Is Eligible.** If you are an Active Employee and you perform service in the Uniformed Services of the United States, federal law provides certain rights to continued coverage under the Plan. An eligible Employee may choose to continue coverage for up to a maximum of 24 months from the date that service commences.

The terms "Uniformed Services of the United States" and/or "Uniformed Services" means the Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

(b) **Coverage for Absences of 31 Days or Less.** If you (and your Dependents) are eligible for benefits as of the date of entry into the Uniformed Services, and your absence is due to a Uniformed Services leave of 31 days or less, coverage will be continued at no cost to you. You will be credited as necessary to keep coverage in effect as if you had worked in Covered Employment with a Contributing Employer during the period of service.

(c) **Coverage for Absences of More than 31 Days.** If you (and your Dependents) are eligible for benefits as of the date of entry into the Uniformed Services, and your absence is due to a Uniformed Services leave of 31 days or more, you (or your Dependents) may elect to continue coverage by:

(i) using available coverage earned (in Dollar Bank reserves) through Covered Employment, or

(ii) self-payment under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

(d) **Maximum Coverage.** The maximum length of USERRA Continuation Coverage is the lesser of:

(i) 24 months beginning on the day that your Uniformed Services leave commences; or

(ii) a period ending on the day after you fail to return to employment within the time allowed by USERRA.

(e) **Effect on Your Dollar Bank.** Funds in your Dollar Bank reserve, if any, will be frozen as of the first day of entry into the Uniformed Services, provided that you do not elect continued coverage for absences of more than 31 days using available coverage earned in Dollar Bank reserves and that you notify the Plan Office no later than five (5) business days prior to the date of entry into the Uniformed Services.

(f) **Reinstatement of Eligibility Following Uniformed Service.** If you were eligible for benefits on the date of entry into the Uniformed Services and upon completion of service you notify the Employer of your intent to return to employment as specified in USERRA, (and within 60 days apply to the Local Trust for reinstatement of any Dollar Bank in existence prior to entry into military service) your eligibility will resume as it was the day before you entered into Uniformed Services. If you remain in or re-enter the Uniformed Services or training without being required to do so, you shall not be entitled to reinstatement.

The Plan pays no benefits for conditions incurred or aggravated during performance of duties in the Uniformed Services. If there is any conflict between these provisions and USERRA, the minimum requirements of USERRA shall govern.

6. **Option to Freeze Dollar Bank Reserves.** Upon leaving Covered Employment, if you have at a minimum, Dollar Bank reserves equal to the AMPC to your credit in the Plan, you will have the option of either running out your balance on the Dollar Bank, or serving notice through the Business Manager of the Local Union within 30 days of leaving Covered Employment of your desire to freeze your Dollar Bank balance for a period not to exceed one year. Retirees who elect a one-time opt out of Plan coverage under Section II.B.8., may freeze their Dollar Banks for a period not to exceed ten years.

(a) **Effective Date of Freezing.** The freezing of your Dollar Bank balance will become effective on the first (1st) day of the calendar month after the date of serving said notice, provided said notice is received by the Plan Office prior to the 15th of the month. If the notice is received by the Plan Office after the 15th of the month the freezing will become effective on the first (1st) day of the second following calendar month.

(b) **Timeline for Unfreezing Dollar Bank.**

(i) Actives. Upon re-entry into Covered Employment within the one-year period from date of serving above notice, you shall be allowed 30 days within which to file notice of your intention to unfreeze your reserve hours. “Covered Employment” as used in this paragraph is defined as the first day contributions are made, or should have been made, on your behalf.

(ii) Retirees. If you are a Retiree who opted out of Plan coverage under Section II.B.8, by no later than ten years from the date of serving notice of opt-out, you shall be allowed 30 days within which to file notice of your intention to unfreeze your reserve hours.

(c) **Coverage Upon Re-entry.**

(i) when freezing your Dollar Bank, unfrozen reserves of less than 2 times the AMPC will allow coverage to begin on the first (1st) of the month following the month you accumulate contributions up to the level of the AMPC following your re-entry; and

(ii) if, upon your re-entry, you unfreeze 2 times the AMPC or more, you will have coverage effective the first (1st) of the month following the month you resume Covered Employment (or notify the Plan office of your request of the unfreezing of your Dollar Bank).

(d) **Dollar Bank Forfeiture.** Your failure to return within one year (or within ten years for Retirees who Opt Out under Section II.B.8.) shall result in forfeiture of your Dollar Bank. In addition, your Dollar Bank will be canceled and any balance will be forfeited if you engage in non-union work of the kind covered under the Collective Bargaining Agreement.

All Dollar Bank balances will be forfeited upon your death, provided there are no eligible surviving Dependents.

7. Continuation Coverage (Temporary) Due to Coronavirus Impact on Covered Employment.

Please refer to Appendix B.

IV. HEALTH & WELFARE BENEFITS

A. HOSPITAL AND MEDICAL BENEFITS (INCLUDING SUBSTANCE ABUSE AND MENTAL HEALTH BENEFITS)

1. Self-Funded Indemnity Plan and Additional Deductible Indemnity Medical Plan.

BENEFITS FOR:

† **ACTIVE MEMBERS AND THEIR DEPENDENTS**

THE BENEFIT:

Subject to annual deductibles, the Plan will pay 80% of all "in-network" Covered Charges, 60% of "out-of-network" Covered Charges and 100% of Covered Charges in excess of $10,000 in a calendar year. The Plan imposes no **lifetime** or **annual** maximum dollar amount for Covered Charges that are considered "essential health benefits" under the Patient Protection Affordable Care Act for both Inside Construction and Motor Shop employees.

(a) **The Annual Deductible.** For the Self-Funded Indemnity Plan, you and your Dependents are responsible for the first $200 of Covered Charges per person during a calendar year, up to a maximum of $400 per family for each calendar year. For the Additional Deductible Indemnity Medical Plan, the per person deductible is $3,574 and $3,774 per family. This is called the annual "deductible." The deductible each calendar year applies separately to each Participant under the Plan. Non-Covered Charges and your coinsurance percentage may not be used to satisfy the deductible amount. (A $250 charge will apply if you or your Dependent fails to choose a participating PPO in-patient Hospital facility when available.)

The deductible amount is subtracted from the Covered Charges and the remaining amount is multiplied by the coinsurance percentage to determine the amount payable.

After two or more individuals in an eligible family have satisfied the family deductible in a calendar year, no further deductible is required of that family unit for Covered Charges incurred in the remainder of that calendar year. "Eligible family" means a Covered Employee and all Dependents as defined in Sections XI and II.C.1, respectively.

Covered Expenses incurred during the last quarter (October, November and December) of a calendar year and applied against the deductible for that year are carried over and used toward satisfying the deductible for the following year. For example, if you have $75 in Covered Charges in November 2020 which is used for the 2020 deductible, this $75 will be carried over and applied to the 2021 deductible. For the Self-Funded Indemnity Plan, this means that you only have to satisfy $125 remainder on the deductible during 2020 ($200 minus $75). For the Additional Deductible Indemnity Medical Plan, this means that you still must satisfy $3,679 during 2020 before the Plan reimburses any portion of the Covered Charges.

The out-of-pocket maximum for prescription drug expenses is no greater than $4,000. In no event, however, will the total out-of-pocket Covered Charges exceed the maximum amount allowable under the Affordable Care Act, which for 2021 is $8,550 per individual and $17,100 per family.

(b) **Payment for Covered Expenses.** If you or your Dependent incurs Covered Expenses during a calendar year as a result of a non-occupational Illness or Injury sustained while eligible under the Plan, benefits will be paid at the appropriate percentage of Covered Expenses, subject to the limitations and provisions listed in this booklet.

(i) **If You Use In-Network Providers (80% of Covered Charges).** After you have satisfied the annual deductible, the Plan will pay 80% of the Covered Expense that are the Reasonable and Customary charges for services and supplies as described in Section IV.A.1(f), below. Covered Expenses must be certified by the attending Physician and determined by the Plan to be Generally Accepted for the care and treatment of Injury or Illness. (See Section XI, Definitions.)

(ii) **If You Use Out-of-Network Providers (60% of Covered Charges).** After you have satisfied the annual deductible, the Plan will pay 60% of the Covered Expense for treatment and services provided by non-PPO providers.

The Plan provides a care management program to assist you and your Dependents in obtaining needed medical care from the most appropriate source available. The care manager will have the option of scheduling services or suggesting methods and providers of care that may not be specifically covered by this Plan. The costs of these special care facilities and treatment will be treated as Covered Charges and reimbursed as outlined above.

(c) **Exceptions.** The following benefits are paid at 100% of the Covered Charges.

(i) **Second surgical opinion.** You may consult a legally qualified Physician on the need of a non-emergency surgical procedure which is otherwise covered under the Plan, including necessary x-ray and laboratory examinations. If the second opinion does not confirm the need for the surgery you may consult a third Physician. Charges incurred for the second and/or third consultation for surgery will be payable at 100% of the first $100 per consultation. For any Reasonable and Customary charges incurred in excess of $100 for the second or third consultation, reimbursement shall be subject to the deductible amount, percentages payable, and maximum amount payable.

(ii) **Convalescent Hospital and Skilled Nursing Facility expenses** are reimbursable after an in-patient Hospital confinement of at least 3 days, up to a maximum reimbursement in accordance with the current Medicare rate, effective February 1, 2015 for out-of-network facilities. PPO rates are applicable for in-network Skilled Nursing Facility expenses. The maximum number of Convalescent Hospital days during any one period of confinement is 100 days, reduced by the number of days of Hospital confinement. Successive Hospital confinements (including Convalescent Hospital confinements) will be considered a single confinement unless they are separated by a period of 30 days or the second confinement is due to a new accidental injury. The Plan will not reimburse expenses in excess of the daily Medicare reimbursement rate. (See Section XI, Definitions for "Convalescent Hospital" and "Hospital.")

(iii) **Preventive Care expenses**. The Plan pays 100% of all Preventive Care "in-network" Covered Charges (see Section IV.A.1.(f)(xxxv) for details on Preventive Care Covered Charges). A complete list of the Preventive Care health services can be found at www.HealthCare.gov/center/regulations/prevention.html.

(d) **Annual Maximum Benefit.** There is no **lifetime** or **annual** maximum dollar amount for Covered Charges that are considered "essential health benefits" under the Patient Protection Affordable Care Act for both Inside Construction and Motor Shop employees.

(e) Self-Funded Indemnity and Additional Deductible Indemnity Medical Plans' Cost Containment Features.

(i) Preferred Provider Organization ("PPO") Network. The Plan has contracted with Anthem Blue Cross, a Preferred Provider Organization Network, to cover Hospital services rendered by participating Hospitals and other providers at predetermined fees. Neither you nor the Plan is responsible for any Hospital charges in excess of the contracted amount. The Plan adopted this PPO-Network as a cost containment measure and the result is a savings to both the Plan and members who use participating facilities. Additionally, some services which are not normally covered under the Plan may be included at no charge at a PPO-Network Hospital.

The Plan has also contracted with Anthem Blue Cross's Physician and practitioner network which covers other medical services at predetermined fees. The network includes primary care and specialty Physicians, clinical laboratories, MRI facilities, physical therapists, chiropractors, mental health providers, and durable medical equipment.

Information regarding these programs, as well as a schedule of providers, is available in the Plan Office at no cost. Note that Anthem Blue Cross's provider network is always growing and changing. Therefore, new providers are regularly being added to the program. It is also possible that a provider is listed in Anthem Blue Cross's directory but may not have renewed their contract with Anthem Blue Cross since the printing of that directory. As such, you are advised to call Anthem Blue Cross at (800) 274-7767 before receiving medical procedures. In addition, if a provider is not listed in your directory, you can call the same number to determine whether that provider is a member of the Anthem Blue Cross provider network.

(I) What is a PPO? A PPO is a network of Doctors, Hospitals, and other health care professionals in your geographic area that offers quality care at competitive prices. When you use providers in the PPO, you usually receive greater medical benefits than by using a non-PPO provider. Using a PPO-Network provider may also reduce personal health care costs.

(II) PPO Advantages. The biggest advantage a PPO offers is choice because you have the freedom to use your current Doctor, choose a new one, or change anytime in the future. You can also choose to use any qualified health care provider and still receive benefits for Covered services, but the Plan will pay only up to 60% for out-of-network provided Covered Charges. The greatest cost savings can be achieved by using PPO providers.

(III) Quality and Savings by Utilizing the PPO.

(A) Quality: Providers in the network are screened to ensure they meet strict quality guidelines. Plus, the PPO plan is designed to meet most health care needs.

(B) Savings: Because PPO providers cannot bill more than the deductible or coinsurance, the portion of the total charges and out-of-pocket costs may be lower. If you do not use a PPO Network health care in-patient Hospital facility, there may be a $250 deductible applied against your benefit, in addition to the annual deductible set forth below. (This additional deductible does not apply to out-of-pocket maximums. Nor does it apply if you are treated by a non-network practitioner or if services are rendered at a non-network outpatient facility. Note: if you or your Dependent seeks treatment at a PPO Network Hospital, but the Doctor or provider who renders services is a non-network practitioner, the PPO discounts will apply.)

(IV) Locating a PPO Provider. A PPO Directory is available at the PPO's website: www.anthem.com/ca. If you require assistance in selecting a PPO provider, contact the PPO directly. Be sure to verify PPO participation prior to every Physician visit.

(ii) Medical and Pre-Admission Review.

(I) What is Medical Review? Medical Review is a predetermination by the Plan's Medical Review Department (Anthem Blue Cross) and/or an independent medical reviewer that a treatment is Medically Necessary. The fact that a Physician may order treatment does not, of itself, make it Medically Necessary, or make the expense a Covered Expense. (See Section XI, Definitions.)

(II) What is Pre-Admission Review? Similarly, Pre-Admission Review is a predetermination of the medical necessity of any proposed Hospital confinement. As the Plan only pays for Medically Necessary hospitalizations, this review process will provide advance approval or denial of benefits for Hospital confinements. Before an in-patient admission to a Hospital, you or your Physician should contact Anthem Blue Cross at (800) 274-7767. Failure to do so may result in a $250.00 charge.

(III) How the Program Works? Once you receive your Identification Card, all scheduled, non-emergency Hospital confinements are subject to Pre-Admission Review. This means that you (or your Dependent), your Physician or your Hospital must call the Review Organization (Anthem Blue Cross) at least 24 hours prior to your (or your Dependent's) scheduled Hospital admission. In cases of emergency hospitalizations, you (or your Dependent), your Physician or your Hospital must call the Review Organization within 48 hours of your (or your Dependent's) admission. The telephone number of the Review Organization will be listed on the Identification Card. The Review Organization will consult with the Physician if necessary and determine if the admission is Medically Necessary and the appropriate length of stay.

(IV) Your Responsibility. It is your and your Dependent's responsibility to notify your Physician of this Hospital Pre-Admission Review requirement. You and/or your Dependent should also confirm with the Hospital at the time of admission that Pre-Admission Review has been obtained.

(V) Penalty for Non-compliance. The failure to comply with the Hospital Pre-Admission Review requirements may result in a reduction in benefit. If Pre-Admission Review is not obtained prior to any non-emergency Hospital admission, no benefits will be payable for the Hospital charges unless Retroactive Review determines the confinement was Medically Necessary.

(VI) Important Exception. The Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following a normal delivery or less than 96 hours following a Cesarean section. No precertification is required for maternity admissions up to the maximum stay indicated above. While it is not necessary to obtain precertification, the Review Organization may be notified of any upcoming maternity admission so they may follow up on the Participant's medical care during hospitalization.

(f) **What Charges Are Covered.** Benefits are payable for the Reasonable and Customary charges for services ordered by a Doctor or other Licensed or Certified Health Care Provider. These are for services, treatment, and supplies for the care and treatment of an Illness or Injury. The Plan will pay benefits as outlined in Section IV.A.1(b), above, for charges as follows:

(i) made by a duly constituted and lawfully operated Hospital for outpatient and in-patient treatment; Covered Charges for in-patient treatment are limited to the Hospital's regular rate for semiprivate accommodations; if the Hospital does not have semiprivate accommodations, the Plan will cover 75% of the minimum daily charges for room and board;

(ii) made by a Hospital for pre-admission testing for diagnostic tests performed and x-rays taken, in the Hospital's outpatient department in connection with a scheduled Hospital admission for treatment of Injury or Illness covered by the Plan, provided tests are:

(I) made within 7 days prior to admission,

(II) ordered by the same Doctor who ordered the admission, and

(III) the same tests that would have been ordered during the Hospital confinement.

(iii) if the scheduled admission is cancelled or delayed, the benefit will still be paid if:

(I) the tests reveal a condition that requires treatment prior to the admission,

(II) a medical condition develops that delays the admission,

(III) a Hospital bed is not available on the scheduled date of admission, or

(IV) the tests indicate that the admission is not necessary.

(iv) for accommodations in an Intensive Care Unit or Coronary Care Unit which are in excess of the semiprivate rate, when required for the treatment of a critically ill or injured insured person;

(v) made by a Licensed Convalescent Hospital or Skilled Nursing Facility subject to the limitations described in Section XI. Definitions.

(vi) for Professional medical services (including clinically appropriate Telehealth services) of a Doctor, registered physical therapist, occupational therapist, anesthesiologist, radiologist or pathologist.

(vii) for Professional services (including clinically appropriate Telehealth services) of a Psychologist, Psychotherapist, or Psychiatrist for treatment of mental and nervous disorders.

(viii) made by a registered nurse (R.N.), a licensed vocational nurse (L.V.N.), or licensed practical nurse (L.P.N.), for private duty nursing service other than a nurse who ordinarily resides in the insured's home or who is a member of the immediate family (the insured, the insured's spouse and children, brothers, sisters and parents of either);

(ix) for surgery performed by the Doctor acting within the scope of his or her license;

(x) for services rendered for outpatient surgery if the Patient undergoes a surgical procedure which would normally be performed in a Hospital but which can be performed in an Ambulatory Outpatient Surgical Facility or a Doctor's office. The patient has the right to choose between having the procedure performed in the Ambulatory Outpatient Surgical facility, the Doctor's office, or in the Hospital. In no event will claims be denied if the

patient chooses to have the surgical procedure performed in the Hospital as an in-patient.

(xi) for initial and subsequent post-mastectomy prosthetic devices and prosthetic appliances such as artificial limbs or eyes;

(xii) for initial truss, brace or support, cast splints, and crutches;

(xiii) for the rental (not to exceed the purchase price) of durable medical equipment such as a wheelchair and Hospital-type bed. Durable equipment means equipment or FDA approved medical devices that are Medically Necessary to aid in recovery, mobility and/or the support of life. Such durable medical equipment must: a) be prescribed by the attending Doctor, b) be designed for prolonged use, c) not be primarily used for non-medical purposes, and d) not be specifically excluded by this Plan;

(xiv) for oxygen and purchase or rental of equipment or its administration. The benefit limit for rental will not exceed the purchase cost;

(xv) for blood or blood plasma not replaced, including the storage of the patient's blood when approved or recommended by the attending Doctor or Surgeon;

(xvi) for a surgical procedure whether or not stored blood is used;

(xvii) for laboratory tests and x-rays;

(xviii) for anesthesia and its administration;

(xix) for use of radium and radioactive isotopes; cancer chemotherapy treatment;

(xx) for transporting the patient to the first Hospital where treatment is given and when Medically Necessary, if such transport: a) is to the nearest facility equipped to provide the required treatment, b) is provided by a licensed professional ambulance service, and c) is land transportation except where land transport is too dangerous or is not available;

(xxi) for drugs and medicine obtainable only upon the written prescription of a Doctor and dispensed by a licensed pharmacist, including insulin and diabetic supplies. Charges for injectable drugs, including syringes and needles for the administration thereof, are also covered. Note: Prescription drug coverage is no longer provided under the Self-Funded Indemnity Plan. These benefits are provided under a supplemental program through Prescriptions Solutions. For more information, refer to Supplemental Benefits described below in Section IV.B.

(xxii) for the treatment of temporomandibular joint dysfunction syndrome ("TMJ"), or any other treatment of the face, neck, or head are covered on the base basis as any other treatment of skeletal system, if the procedure is Medically Necessary to treat a condition caused by congenital deformity Injury or Illness. However, charges for intra-oral prosthetic devices are excluded;

(xxiii) for services of a licensed acupuncturist which may be covered as a standard medical benefit for Reasonable and Customary expenses, depending upon the diagnosis. You should contact the Plan Office prior to scheduling treatment to determine whether or not coverage is applicable to your specific Illness or Injury. The Plan will cover 15 visits per Illness or Injury. Charges for additional visits will be subject to review;

(xxiv) for Reasonable and Customary expenses by Generally Accepted chiropractic standards when treated by a licensed chiropractor. Plan will cover a maximum of 30 visits per Illness or Injury per calendar year, with charges for additional visits subject to

chiropractic review. You should contact the Plan Office for an evaluation before starting treatment since the number of visits may be limited depending upon the nature of Illness or Injury;

(xxv) for maternity-related services for a member, spouse or Domestic Partner. Charges due to elective abortion shall not be considered a Covered Expense except for those charges incurred for an abortion where the life of the mother would be endangered if the fetus were carried to term, or those charges which directly result from complications of an abortion. Expenses for well-baby care are not covered, with the exception of a well-baby Physician's Hospital visit at the time of release from the Hospital. Note: A female member, spouse or Domestic Partner who is pregnant on the date of termination of her coverage will be entitled to the applicable benefits for covered expenses due to her pregnancy even though she may not be totally disabled on the date of termination provided (a) the pregnancy commenced while such individual was eligible for coverage under the Plan, and (b) such individual is not eligible for coverage under any other group plan providing similar benefits for the pregnancy.

(xxvi) charges for maternity care will be provided on the same basis as any other Illness. However, expenses for in-patient Hospital treatment for childbirth delivery will be provided for the mother for: (I) 48 hours following normal vaginal delivery; and (II) 96 hours following delivery by Caesarean section.

(xxvii) the mother and newborn child may be discharged earlier than the above indicated time periods if both of the following conditions are met: (I) the treating Doctor or Other Licensed Health Care Provider in consultation with the mother make the decision to discharge the mother and child for an earlier time period; and (II) a post-discharge follow-up visit for the mother and newborn child is provided within 48 hours of discharge, when: (A) prescribed by the treating Doctors; and (B) the visit is provided by a Licensed Health Care Provider whose scope of practice includes postpartum care and newborn care, and may include parent education, assistance and training in breast or bottle feeding; and the performance of any necessary maternal or neonatal physical assessments.

(xxviii) charges for sterilization of the reproductive system, including vasectomy and tubal ligation.

(xxix) for services by a stand-by surgeon when Medically Necessary due to the risk of the surgical procedure.

(xxx) for newborn nursery care; limited to one well-baby Hospital visit and nursery care charges for up to 48 hours following normal vaginal delivery by mother; and up to 96 hours following delivery by Caesarean section.

(xxxi) for contact lenses or eyeglasses and frames required immediately following and as a result of cataract surgery.

(xxxii) for the treatment of osteoporosis. Covered expense will include all Food and Drug Administration ("FDA") approved technologies, including bone mass measurement technologies as deemed medically appropriate by a Doctor.

(xxxiii) for prosthetic devices to restore a method of speaking for the patient incident to a laryngectomy. Covered Expenses will include the initial and subsequent prosthetic devices or installation accessories, as prescribed by the treating Physician, but will not include electronic voice producing machines.

(xxxiv) for one flu shot per year from any flu shot provider.

(xxxv) for Preventive Care items or services. A complete list of the Preventive Care health services can be found at www.HealthCare.gov/center/regulations/prevention.html.

If a Preventive Care item or service is billed separately from an office visit, the office visit may not be treated as a Preventive Care Covered Charge. If a Preventive Care item or service and office visit are not billed separately and the primary purpose of the office visit is the delivery of the Preventive Care item or service, the office visit will be treated as a Preventive Care Covered Charge; but if the delivery of the Preventive Care item or service is not the primary purpose of the office visit, the office visit may not be treated as a Preventive Care Covered Charge. A Preventive Care item or service may not be treated as a Preventive Care Covered Charge until the first day of the Plan year beginning on or after the date on which the service or treatment is designated as a Preventive Care item or service.

(xxxvi) for Medically Necessary health education for diabetes management.

(g) **What Charges Are Not Covered.** The benefits of the Plan are provided only for services and supplies which are Medically Necessary. These services are Covered services and supplies which are consistent with the symptoms or diagnosis in treatment of the Illness or Injury, are Medically Necessary and consistent with Generally Accepted professional standards, are not furnished primarily for the convenience of the patient, the Doctor, or other provider, and are furnished at the most appropriate level which can be provided safely and effectively to the patient. Examples of services which are not Medically Necessary include hospitalization for diagnostic studies that could have been provided on an outpatient basis, hospitalization primarily for observation or evaluation, hospitalization to remove the patient from his or her customary work and/or home environment or for personal comfort.

The Plan reserves the right to determine if a service, supply, or hospitalization is Medically Necessary. The fact that a Doctor or other provider has prescribed, ordered, recommended or approved a service, supply, or hospitalization does not, in itself, make it Medically Necessary.

The following charges are **NOT** Covered Expenses:

(i) Any portion of a charge which is in excess of the Reasonable and Customary charge for the treatment;

(ii) Any charge for treatment that the Plan determines is not Medically Necessary. To determine this, the Plan may rely upon the advice of its medical review department and/or an independent medical reviewer and other medical experts. This provision shall not exclude any Covered Expense which specifically states that such treatment will be considered Medically Necessary under the policy;

(iii) Charges incurred for a treatment that is not Generally Accepted by the medical profession, or is listed as experimental, under investigation, or limited to research:

(I) by the federal Food and Drug Administration ("FDA"); the American Medical Association ("AMA"); Diagnostic and Therapeutic Technology Assessment ("DATTA"); or the Office of Medical Application of Research of the National Institute of health Office of Technology Association ("OMT"); or

(II) if a treatment has not been addressed by one of the organizations listed in Section IV.A.1(g)(iii)(I), above, the Plan has the right to determine if a treatment is appropriate based on the advice of its medical review department and/or an independent medical reviewer and other medical experts.

However, coverage will not be denied for an FDA-approved drug that is used to treat a condition for which the FDA has not approved the drug's use, if all of the following conditions have been met:

(A) the drug is prescribed for the treatment of a life-threatening condition. "Life-threatening" means either or both of the following:

(1) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; and/or

(2) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival; and

(B) The drug has been recognized for treatment of that condition by one of the following:

(1) the American Medical Association Drug Evaluations;

(2) the American Hospital Preferred Service Drug Information; or

(3) the United States Pharmacopoeia Dispensing Information, Volume I, "Drug Information for the Health Care Professional."

(iv) Charges incurred for surgery to the eye to correct a refractive error, such as Lasik; charges incurred for the purchase or fitting of eye glasses or contact lens. However, charges incurred for a contact lens or eye glasses and frames required immediately following and as a result of cataract surgery will be a Covered Medical Expense;

(v) Charges incurred in connection with treatment that is Cosmetic; other than:

(I) reconstructive surgery to restore tissue damaged by Injury or Illness, including surgery on one or both breasts to reestablish symmetry following a mastectomy; or

(II) treatment of a child from birth to correct a congenital disease or anomaly, including an oral defect;

(vi) Charges incurred for an elective abortion, except where the life of the mother is in danger if the procedure is not performed;

(vii) Charges incurred for Custodial Care;

(viii) Charges which a member is not legally obliged to pay for; or treatment which s/he obtains, or is entitled to obtain, under any plan or program without charge, except Medicaid or Medi-Cal. This will include charges for treatment which is provided or paid for by the federal government at a Veteran's Administration facility for: (I) an Injury or Illness related to the patient's military service; or (II) the member or his or her Dependents, if retired from the armed services;

(ix) Charges incurred as a result of an act of war, whether declared or not, or any related act; charges incurred as the result of participation in a riot or civil disorder;

(x) Charges incurred as a result of: (I) an Injury which arises out of or in the course of any employment with any Employer; or (II) an Illness for which the Member or Dependent is entitled to benefits under any workers' compensation law or occupational disease law; or (III) an Injury or Illness for which the Member or Dependent receives any settlement from a workers' compensation or occupational disease carrier;

(xi) Charges for transportation, except professional ambulance services;

(xii) Charges incurred in connection with: (I) artificial insemination; (II) in vitro fertilization; and (III) in-vivo fertilization;

(xiii) Charges items used for an individual's personal comfort, such as air purifiers, humidifiers, whirlpools, Jacuzzi or hot tub devices, exercise equipment, reclining chairs, bed boards, or other equipment not primarily medical in nature;

(xiv) Charges for multiple and non-therapeutic vitamins, dietary supplements, weight-control items, health and beauty aids are not covered, nor is any drug which is not Medically Necessary for the care of treatment of Illness or Injury;

(xv) Charges incurred for which a third party is responsible.

2. Health Maintenance Organizations. In place of the medical benefits provided by the Self-Funded Indemnity Plan, as set forth above in Section IV.A.1, there are Health Maintenance Organizations, ("HMO") programs available to provide coverage to you and your Dependents. A description of these benefits is included in separate booklets prepared by the HMOs which are available in the Plan Office. Not all of these HMOs are available to all Participants because HMOs' service areas may not include the area in which the Participant lives. Participants who wish to elect or discontinue coverage in any of the HMO programs may do so once in a rolling 12-month period. The non-payment of any Buy Up for HMOs that require additional payment will result in a default and you will automatically be enrolled in the Additional Deductible Indemnity Medical Plan for one year.

If you elect an HMO, none of the medical benefits described in this booklet will apply to you with the exception of the Supplemental Benefits described below in Section IV.B of this booklet. Since each HMO has its own appeal procedures, the Claims and Appeal Procedures described in Appendix A of this booklet will also not apply to you for benefit claims. You must refer to the applicable HMO's individual program descriptions to determine what benefits are available and, in the event of a full or partial denial, its specific appeal procedures. Further, you should be aware that any claim for malpractice under these HMOs is generally subject to the arbitration procedures set forth in the contract between the Board of Trustees and the HMO provider. Further information may be obtained from the Plan Office or directly from the HMO provider.

Benefits that are available to most Active member Plan Participants regardless of your program election include prescription drug, dental, substance abuse, life insurance, accidental death and dismemberment benefits. These are benefits described in IV.B, Supplemental Benefits.

The following HMO plans are presently available:

Kaiser Health Plan/Senior Advantage

1950 Franklin
Oakland, CA 94612
Member Services: (800) 464-4000
Senior Advantage: (800) 443-0815

United Healthcare (UHC)/UHC Medicare Advantage National PPO Plan
Box 29650
Hot Springs, AR 71903
(888) 219-4602

B. SUPPLEMENTAL BENEFITS

In addition to the hospital medical benefits described in this booklet, the Plan provides certain supplemental benefits to certain Participants, as follows: prescription drug, dental, vision, hearing, life insurance and accidental

death and dismemberment benefits. The following represents a summary of the supplemental benefits and programs now available.

1. Mandatory Generic Prescription Drug Card Program.

BENEFITS FOR:

- † **ACTIVE MEMBERS AND THEIR DEPENDENTS**
- † **EARLY (NON-MEDICARE) RETIREES AND THEIR DEPENDENTS (Not L595 Motor Shop Retirees or their Dependents)**
- † **SURVIVING SPOUSES AND DEPENDENT CHILDREN OF ELIGIBLE RETIREES (Only if they are Non-Medicare eligible)**

THE BENEFIT:

All prescription drug benefits are covered through Optum Rx's prescription drug card program. With the exception of Kaiser enrollees, this program replaces the prescription drug programs that were available through the HMOs.

The Plan's co-payment schedule is summarized below:

	GENERIC DRUG CO-PAY	**BRAND CO-PAY** ("Optum Rx Preferred")	**BRAND CO-PAY** ("Non-Preferred")
30-Day Retail Supply	$5.00	$20.00	$35.00
90-Day Retail Supply	$15.00	$60.00	$105.00
90-Day Mail Order Supply	$10.00	$40.00	$70.00

Mandatory Generic Substitution

Mandatory generic substitution helps manage plan costs by reimbursing the cost of your prescription drug up to the price of the lowest-priced alternative medication, which is typically a generic drug. If the drug you are

prescribed is a brand-name drug and there is no alternative or interchangeable drug, your plan will continue to reimburse your prescription based on the level of the brand-name drug.

Effective with claims incurred on or after June 1, 2020, the Prescription Drug benefit for the UnitedHealthcare HMO and Indemnity PPO Plan will include a Mandatory Generic Substitution. If a member receives a brand name prescription where there is a generic alternative available, the Plan will only pay the amount equal to the generic prescription drug. This only applies if there is a generic alternative.

In rare instances, an individual cannot tolerate the generic drug, or it is therapeutically ineffective. When this happens, medical evidence can be submitted to support why the brand-drug is being prescribed. If approved, your prescription will be reimbursed based on the cost of the brand-name drug.

High-Cost Generics

Effective June 1, 2020, the Prescription Drug benefit for the UnitedHealthcare HMO and Indemnity PPO Plan will include an exclusion for higher-cost generic products when a lower-cost generic equivalent becomes available.

High-Cost Brands with Generics

Effective June 1, 2020, the Prescription Drug benefit for the UnitedHealthcare HMO and Indemnity PPO Plan will include an exclusion for higher-cost brand products when a generic clinically equivalent, lower-cost option is available.

Additional information, including a complete listing of participating pharmacies, is available on Optum Rx's website, www.optumrx.com, or by calling Optum Rx at (800) 797-9791.

Prescription drug benefits are available for Medicare-eligible Retirees through UHC Medicare Advantage National PPO Plan or Kaiser Senior Advantage.

ALERT: MEDICARE-ELIGIBLE RETIREES

Medicare-eligible Retirees are eligible for a new prescription drug program under Medicare Part D. Your coverage in the current prescription drug plan provided through the Plan (i.e., through the UHC Medicare Advantage National PPO Plan or the Kaiser HMO) is not affected by the new Medicare prescription drug program. You continue to have coverage under the Plan's drug program; therefore, **it is not necessary for you to enroll in Medicare Part D offered outside of the Plan with a non-Plan provider.** If you choose to enroll in a Medicare Part D program outside of the Plan, you will lose coverage under the Plan and not be allowed to re-enroll.

The prescription drug benefit you currently receive under the Plan provides better coverage, at less cost to you, than the new drug program under Medicare Part D. As long as you are eligible to have prescription drug coverage through the Plan, 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.

Please note that while the Plan advises you NOT to enroll in Medicare Part D at this stage, you must still enroll for both Medicare Part A and Part B to be eligible for full coverage in this Plan.

2. Dental Benefits.

BENEFITS FOR:

- † **ACTIVE MEMBERS AND THEIR DEPENDENTS**
- † **RETIREES AND THEIR DEPENDENTS (Not L595 Motor Shop Retirees or their Dependents)**
- † **SURVIVING SPOUSES AND DEPENDENT CHILDREN OF ELIGIBLE RETIREES**

THE BENEFIT:

Dental benefits are currently provided under contract with the Delta Dental Plan ("Delta Dental"), or alternatively, through United Healthcare ("UHC") Dental, an HMO.

Dental Benefits are not available for Participants enrolled in the Additional Deductible Indemnity Medical Plan.

The following represents a brief summary of the benefits that are available through this program and is provided for information only. Separate booklets describing these programs in detail are available in the Plan Office.

(a) Delta Dental. To use the Delta Dental program, members may make an appointment with any dentist of their choice. All Delta Dental dentists will have treatment forms in their offices and will complete and submit them to Delta Dental for reimbursement. A complete list of Delta Dental dentists may be obtained by calling (888) 335-8227.

Local 595 **% of Delta Dental Fee Schedule**	
Diagnostic & Preventive Benefit	100%
Basic Benefits (oral surgery, restorative treatment, Endodontics, periodontics)	80%
Crowns, jackets & Cast Restorations	80%
Prosthodontic Benefits	80%
Orthodontic Benefits $2,500 Lifetime maximum	80%,
Calendar Year maximum $2,000	
Deductible $25 per individual and $75 per family per calendar year (excludes diagnostic and preventive services from a PPO dentist)	

(b) United Healthcare ("UHC") Dental. UHC Dental is a closed panel dental provider and may be elected in lieu of Delta Dental. (See separate UHC Dental booklet for details.)

3. Vision Benefits.

BENEFITS FOR:

- † **ACTIVE MEMBERS AND THEIR DEPENDENTS**
- † **RETIREES AND THEIR DEPENDENTS**

THE BENEFIT:

Vision benefits are currently provided to eligible Active members and their Dependents and Early (Non-Medicare) Retirees and their Dependents under contract with the Vision Service Plan ("VSP") provided they are not enrolled in the Additional Deductible Indemnity Medical Plan.

Vision coverage is provided to Medicare Retirees through the medical plans in which they are enrolled.

The following represents a summary of benefits through **VSP**:

Coverage

- Examination every 12 months
- Lenses and Frames every 24 months
- Safety glasses, one pair every 24 months
- $20 co-payment

A separate VSP booklet discussing this Plan is available in the Plan Office.

4. Hearing Benefits.

BENEFITS FOR:

- † **ACTIVE MEMBERS**

THE BENEFIT:

Hearing Protection benefits are provided to eligible Local 595 Active members. The Plan will provide each Active member a custom fit hearing protection plug reimbursed up to the amount of $100 per lifetime.

The hearing protection plug can be purchased from Pacific Coast Laboratories, a designated vendor. The Active member must complete a Hearing Protection Benefit claim form and submit a proof of purchase (receipt) to the Fund Office for reimbursement.

5. Death Benefits.

BENEFITS FOR:

† **ACTIVE LOCAL 595 MEMBERS (Including Local 595 Motor Shop)**

THE BENEFIT:

Life Insurance Benefit is provided to eligible Local 595 Actives only. For Participants who die from any cause while eligible as an Active member, life insurance benefits of $15,000 will be paid to your beneficiary.

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form. The change will be effective when the Plan Office receives the completed form. If your beneficiary dies before you, that beneficiary's interest automatically terminates. If there is no beneficiary designated by you, or if the designated beneficiary does not survive you, then the benefit payment will be made to the first surviving class of: your spouse, your children, your parents, your brothers and sisters, or to your executor or administrator. Up to $500 of the proceeds may be paid to your beneficiary or relative or other person who has paid for burial expenses.

6. Accidental Death and Dismemberment Benefits.

BENEFITS FOR:

† **ACTIVE LOCAL 595 MEMBERS ONLY (Not L595 Motor Shop Members or any Dependents)**

THE BENEFIT:

This benefit provides 24-hour coverage for Active Local 595 members only if the Active member sustains any of the losses listed below as a result of an accident. The loss must take place within 90 days from the date of the accident in order for benefits to be payable.

(a) Who Will Receive Benefits. For loss of life, benefits will be paid to the beneficiary you name. If there is no beneficiary designated by you, or if the designated beneficiary does not survive you, then the benefit payment will be made to the first surviving class of: your spouse, your children, your parents, your brothers and sisters, or to your executor or administrator. For any other loss, the benefits will be paid to you.

(b) Benefit Amount.

FOR LOSS OF:	THE BENEFIT IS:
Life	The Principal Sum
Two hands	The Principal Sum
Two feet	The Principal Sum
Sight of two eyes	The Principal Sum
One hand and one foot	The Principal Sum
One foot and sight of one eye	The Principal Sum
One hand or one foot	One-half the Principal Sum
Sight of one eye	One-half the Principal Sum

If you suffer more than one loss in any one accident, no more than the full amount of your benefit will be paid. The full amount is the Principal Sum, which is equal to $15,000.

(c) **Beneficiary.** You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form. The change will be effective when the form is received by the Plan Office.

(d) **What Is Not Covered.** No benefit is payable under this paragraph if your death or any loss is caused directly or indirectly, wholly or partly, by:

(i) bodily or mental Illness or disease of any kind;

(ii) ptomaine or bacterial infection (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);

(iii) intentional self-destruction or self-inflicted injury, while sane or insane;

(iv) participation in the commission of a felony;

(v) war or act of war; service in any military, naval or air force of any country while such country is engaged in war or police duty as a member of any military, naval or air organization.

C. LONG-TERM DISABILITY PROGRAM

This Program was SUSPENDED as of October 1, 2011.

D. MEMBER ASSISTANCE PROGRAM

BENEFITS FOR:

† **ACTIVE EMPLOYEES AND MEMBERS OF THEIR HOUSEHOLDS**

THE BENEFIT:

The Member Assistance Program ("MAP") is a program of Optum Behavioral Health. This program offers benefits at no cost to Participants, including confidential counseling and referral services designed to help Active members and members of their households to resolve personal problems that may be interfering with work or home life. The Plan provides up to 8 sessions per incident per person.

Please refer to the separate MAP booklet for details.

E. LIVEHEALTH ONLINE ("LHO") CARE SERVICE PROGRAM – INDEMNITY PLAN ENROLLEES ONLY

BENEFITS FOR:

† **ACTIVE EMPLOYEES AND MEMBERS OF THEIR DEPENDENTS WHO ARE ENROLLED IN THE SELF-FUNDED INDEMNITY PLAN OR ADDITIONAL DEDUCTIBLE INDEMNITY MEDICAL PLAN ("INDEMNITY PLANS")**

† **EARLY RETIREES (NON-MEDICARE), THEIR DEPENDENTS, AND THEIR SURVIVING SPOUSES WHO ARE ENROLLED IN THE INDEMNITY PLANS**

THE BENEFIT:

LiveHealth Online is a program of Anthem Blue Cross. LHO is an online care service program that offers non-emergency benefits at a low cost of $10 co-pay per visit to Participants who are enrolled in one of the Indemnity plans. The benefits include access to medical doctors, psychologists, and therapists who are available 24 hours, 365 days per year and who can provide a diagnosis, treatment, or prescriptions if needed.

Please refer to the separate LHO materials for details on how to access this benefit. Note that the $10 co-pay is not applicable to annual deductible or out-of-pocket maximum. In addition, this benefit is in addition to benefit programs available under medical, hospital, and (for Active Employees and their Dependents) MAP benefits.

F. HEALTH REIMBURSEMENT ACCOUNT PLAN ("HRA")

BENEFITS FOR:

† **ACTIVE EMPLOYEES AND DEPENDENTS**

THE BENEFIT:

The Health Reimbursement Account Plan ("HRA") is a separate program under the Plan that provides coverage to Plan Participants, their spouses and Dependents for qualified medical expenses such as co-payments, and prescription drugs both within and beyond the Plan. HRA funds can be used for reimbursement for any qualified medical care expense covered under IRC Section 213(d). HRA funds cannot be used for death benefits, accidental death and dismemberment benefits, and long-term disability benefits. Like all Plan benefits, the HRA is not a vested benefit. The Board of Trustees shall have the exclusive right, in their sole and absolute discretion, to administer or terminate any provisions of the Plan, including the HRA accounts.

1. Who Will Receive HRA Benefits: Establishing Your Account.

(a) Establishment of Account. A new HRA Plan account is automatically established for Active Plan participants based on a per hour employer contribution for Active Plan Participants who have worked in Local 595's jurisdiction in June 2008 or thereafter.

2. Benefits.

(a) Plan Benefits. HRAs can be used for reimbursement for self-payments, gap payments, COBRA, as well as co-payments and deductibles for all benefits currently covered by the Plan except death benefits, accidental death and dismemberment benefits, and long-term disability coverage.

(b) Internal Revenue Code Section 213(d) Qualified Medical Expenses. In addition to being able to use your HRA funds for out-of-pocket benefits under the Plan, you and your Dependents can also use HRA funds to pay for any eligible medical care expense described in Section 213(d) of the Internal Revenue Code.

According to Internal Revenue Service Publication 502, Medical and Dental Expenses, eligible "medical expenses" that are deductible under Section 213 are described as follows.

> Medical expenses are the costs of diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of equipment, supplies, and diagnostic devices needed for these purposes.
>
> Medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. They do not include expenses that are merely beneficial to general health, such as vitamins or a vacation.

> Medical expenses include the premiums you pay for insurance that covers the expenses of medical care, and the amounts you pay for transportation to get medical care. Medical expenses also include amounts paid for qualified long-term care services and limited amounts paid for any qualified long-term care insurance contract.

Publication 502 lists the following as "medical expenses" — these would be reimbursable with HRA Plan account funds. Note: The Internal Revenue Service publishes Publication 502 annually and the list of expenses included as a medical expense may change from year to year. The list below refers to the list used for the 2020 tax year only. (See http://www.irs.gov/publications/p502/index.html, which contains detailed information regarding each bullet point listed for the 2020 tax year.) **Because this list may change in 2021 and tax years occurring after the printing of this Summary Plan Description booklet, we strongly recommend that you confirm whether the expense you have is reimbursable before you submit it for payment by your HRA account.**

- Abortion
- Acupuncture
- Alcoholism (In-patient treatment at a therapeutic center for alcohol addiction, including meals, lodging by the treatment center. Also includes travel/transportation to AA meetings provided that attendance is necessary for the treatment of a disease involving excessive use of alcoholic liquors.)
- Ambulance
- Annual Physical Examination (This is already covered as preventive service.)
- Artificial limb
- Artificial teeth
- Bandages
- Birth Control Pills (This is already covered as preventive treatment.)
- Body scan
- Braille Books and Magazines
- Breast Pumps and Supplies
- Breast Reconstruction Surgery
- Capital Expenses (See publication)
- Car (cost of special design, i.e. hand controls or other special equipment)
- Chiropractor
- Christian Science Practitioner
- Contact Lenses
- Crutches
- Dental Treatment (Does not include teeth whitening.)
- Diagnostic Devices
- Disabled Dependent Care Expenses
- Drug Addiction
- Drugs
- Eye Exam

- Eyeglasses
- Eye Surgery
- Fertility Enhancement
- Founder's Fee
- Guide Dog or Other Service Animal
- Health Institute
- Health Maintenance Organization (Premiums)
- Hearing Aids
- Home Care (Nursing Services)
- Hospital Services
- Insurance Premiums (Premiums paid under the Plan are not reimbursable.)
- Medicare Parts B and D premiums
- Prepaid Insurance Premiums
- Unused Sick Leave Used to Pay Premiums
- Intellectually and Developmentally Disabled, Special Home
- Laboratory Fees
- Lactation Expenses
- Lead-Based Pain Removal
- Learning Disability
- Legal Fees (Those fees that are necessary to authorize treatment for mental Illness, but not for management of guardianship estate.)
- Lifetime Care - Advance Payments
- Lodging
- Long-Term Care
- Meals at a hospital
- Medical Conferences (Does not include lodging at a conference.)
- Medical Information Plan
- Medicines
- Nursing Home
- Nursing Services
- Operations
- Optometrist
- Organ Donors
- Osteopath
- Oxygen
- Physical Examination
- Pregnancy Test Kit
- Prosthesis
- Psychiatric Care
- Psychoanalysis
- Psychologist
- Special Education
- Sterilization

- Stop-Smoking Programs
- Surgery
- Telephone (Covers cost of special telephone equipment for hearing or speech disabled communication, e.g., TTY, TDD equipment.)
- Television (Covers units that display audio part of television program with subtitles for persons with a hearing disability.)
- Therapy
- Transplants
- Transportation and Trips (Covers expenses to, from, and for medical care)
- Tuition (This includes costs related to Special Education)
- Vasectomy
- Weight-Loss Program
- Wheelchair
- Wig
- X-Ray

3. **Benny™ Prepaid Card.** In order to provide a more convenient method to access your HRA benefits, the Plan has provided participants the BennyTM Prepaid Card. The BennyTM Card is a debit card which is issued to each Participant under the Plan. This BennyTM Card can be utilized at the point of service at pharmacies, healthcare providers, discount stores, department and supermarkets that accept MasterCard to pay for any Qualified Medical Expense for you or any Eligible Dependent.

Activation. In order to use the Benny™ Card you will be required to activate the Card by going to the web site listed on the back of your Card or following the instructions on the Card sticker. It is necessary to sign the back of your Card(s) and you should check with the Plan Office or through the Participant Website (www.ibew595benefits.org) to verify that there are funds available. Wait one (1) business day after activation to use your Card.

(a) **Use your Benny™ Card** for qualified expenses only, for you and your covered Dependents. You can use your Card only at healthcare providers, pharmacies, discount stores, department stores and supermarkets wherever MasterCard debit cards are accepted that can identify qualified items at checkout. When you use your Benny™ Card at one of the participating stores, you will NOT have to supply a receipt to verify a purchase, except as noted below. If a store is not participating, your Card may decline due to IRS regulations. You can also use your Card to pay for medical bills for any Qualified Medical Expenses that are not paid for by another source like a health plan (e.g. Health plan deductibles and coinsurance) by entering the Benny™ Card number on the Patient Balance Due statement or for mail service and online pharmacies.

(b) **Save All Itemized Receipts** — You may be contacted by your Plan Administrator to submit certain receipts to verify expenses to comply with IRS guidelines. If you are asked to provide a receipt, it must include: merchant or provider name, service received date of service and amount of the expense. Cancelled checks, handwritten receipts, Benny™ Card transaction receipts or previous balance receipts cannot be used to verify an expense.

(c) Check your balances often – Check your balance through the Participant website (www.ibew595benefits.org) or through the phone number on the back of your Benny™ Card. Remember, funds are available in your HRA as they are contributed into the Plan but might take a couple of days to be applied to your account once the contributions are received. Make sure that you have sufficient funds in your account to cover your expenses. If the expense is more than your HRA balance, you may be able to use the Benny™ Card for the exact amount left in your account and use another form of payment for the difference. Check with the merchant.

4. Administration Fee. There is a monthly charge for administering the HRA program. Currently, as of the publication of this booklet, the monthly fee is $3.84 per HRA account. This fee is subject to change at any time at the sole and exclusive discretion of the Plan's Board of Trustees.

5. Plan Participation and HRA Benefits.

The following special rules are applicable to the HRA program, which are benefits integrated in the IBEW Local 595 Health and Welfare Plan.

(a) HRA Funds Can Be Used When Your Dollar Bank Is Exhausted. If you lose coverage under the Plan due to a reduction of hours and exhaustion of your Dollar Bank reserves, but you have unused funds remaining in your HRA account, you and your Dependents can continue to draw down that balance for reimbursement for qualified medical benefits, including the purchase of COBRA coverage, a separate private insurance policy, and/or premium payments for coverage under an Affordable Care Act established Healthcare Exchange.

(b) HRA Funds Can Be Used By Your Surviving Dependents. Upon your death, any balance remaining in your HRA account can be used by your surviving Dependents until that account balance is exhausted.

(c) Forfeiture. If, upon your death, you have no surviving Dependents, any HRA funds remaining in your account will be forfeited.

(d) No Eligibility for Healthcare Exchange Premium Tax Subsidies. According to the federal regulations in effect at the time of this booklet's publication, if you have any funds in your HRA account, you will not be eligible for any of the federal premium tax subsidies that may be available through the Healthcare Exchange established by the Affordable Care Act, even if you otherwise meet the income qualifications.

V. GENERAL PROVISIONS

A. PROOF OF CLAIM

All benefits under the Plan are payable upon receipt by the Plan Office of written proof satisfactory to the Board of Trustees covering the occurrence, character, and extent of the event for which claim is made on a form provided by or satisfactory to the Trustees.

B. EXAMINATION

The Board of Trustees or its duly appointed representative will have the right and opportunity to examine the person of a Participant during the pendency of a claim.

C. NOTICE OF CLAIM

Claims for benefits under the Plan, including the Health Reimbursement Accounts, must be filed at the Plan Office within twelve (12) months following the first day of medical care, treatment, or receipt of supplies, otherwise benefits will be payable only for the period, if any, beginning twelve (12) months prior to the date the claim is filed.

The Board of Trustees may, at its discretion, extend the above time limit in the event evidence is produced in a form satisfactory to the Trustees that it was not reasonably possible to furnish timely proof.

Except as limited above, all Plan rules, benefits, limitations or exclusions will be applied to each claim filed on the basis of the date expense was incurred for which the claim is made.

In no event will benefits paid by this Plan exceed the Usual, Customary and Reasonable charge for the service or supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned.

D. PAYMENT OF CLAIMS

Benefits are payable to the eligible Active Employee or Retiree or Dependent, or in the case of Life Insurance and Accidental Death benefits, the designated beneficiary, provided however, that the Trustees, in their discretion, may pay such benefits to a Hospital or Physician furnishing services, supplies, care or treatment for benefits which are payable, or reimbursement to any person, including a Dependent, who has paid the Hospital or Physician for such services, supplies, care or treatment. Such payments will constitute a full discharge of the liability of the Board of Trustees and Plan to the extent of the benefits so paid.

E. LIMITATION OF ACTION

No action at law or in equity will be brought to recover under this Plan prior to the exhaustion of the Claim and Appeal Procedures described in Appendix A, nor will such action be brought at all unless brought within one year after the date of loss upon which the cause of action is based.

F. NON-ASSIGNMENT OF BENEFITS

With the exception of medical benefits assigned to a Hospital or Physician, no eligible Active Employee, Retiree, Dependent, or beneficiary will have the right to assign, alienate, transfer, sell, hypothecate, mortgage, encumber, pledge, commute, or anticipate a benefit payment hereunder. Benefits are not subjected to any legal process or levy execution upon or attachment or garnishment proceedings against for the payment of any claims.

G. ADDITIONAL PROVISIONS

1. **Authority of Board of Trustees.** The Board of Trustees may establish rules and procedures for the proper administration of the Plan. The Trustees have the discretion and the exclusive authority to interpret the Plan and any rules and procedures established under the Plan and to determine the rights of claimants under the Plan and under those rules and procedures.

The Trustees may delegate some or all of their authority and responsibility in connection with the administration of the Plan to authorize employees of the Plan Office to and to entities such as insurance companies and third-party administrators.

2. **Plan Provisions Are Controlling.** No person can have any right or claim to a benefit from the Plan other than those specifically granted by the terms of the Plan.

3. **Exhaustion of Remedies.** Before initiating legal action to recover any benefit under the Plan, to enforce any right under the Plan or to clarify any right to benefits under the Plan, the person claiming the benefit or right must first comply with the Internal Claims and Appeals Procedure in this Plan Document and Summary Plan Description.

4. **Severability.** If any provision of the Plan is held invalid, the validity of the balance of the Plan will not be affected.

5. **Insurance Refunds, Rebates, and Demutualization Payments.** The Plan is the policyholder for all insurance contracts related to providing Plan benefits. As such, from time to time, the Plan may receive insurance refunds, rebates, experience returns, dividends, or demutualization payments (collectively referred to as the "Insurance Refunds"). Any such Insurance Refunds will be Plan assets and, pursuant to the Trustee's sole discretion, will be used to pay for any combination of additional benefits, Plan expenses, or insurance premiums. No Participant has a vested right to receive any portion of the Insurance Refunds.

6. **Miscellaneous.**

(a) If a person furnishes incorrect or incomplete information in order to qualify for eligibility or benefits, avoids paying all or a portion of an applicable co-payment or deductible by reason of an assigned reimbursement claim that misstates the amount actually charged by a provider of services, or otherwise mistakenly received benefits, the Trustees, in their sole, absolute, and unreviewable discretion, may, through collection proceedings and/or by offset of the overpaid amount(s) against other benefits payable by the Plan, seek reimbursement from such person of the overpaid amount(s) and any amounts expended or incurred in investigating the matter and collecting the overpayment(s) (including, but not limited to, expenses of the Trustees' staff and reasonable fees of any investigators, attorneys, and/or consultants retained by or on behalf of the Trustees). The Trustees also may, in their sole, absolute, and unreviewable discretion, suspend eligibility or benefits with respect to such person, and take any other action they may deem necessary or appropriate under the circumstances.

(b) If a third-party provider of benefits hereunder, through error, misrepresentation, or fraud, receives payment of Welfare Fund assets in an amount greater than the amount authorized under the Plan, the Trustees, in their sole, absolute, and unreviewable discretion, may collect the amount of any such overpayment(s) and any amounts expended or incurred in investigating the matter and collecting the overpayment(s) (including, but not limited to, expenses of the Trustees' staff and reasonable fees of any investigators, attorneys, and/or consultants retained by or on behalf of the Trustees). The Trustees also may, in their sole, absolute, and unreviewable discretion, suspend eligibility or benefits with respect to such person who improperly receives benefits, and take any other action they may deem necessary or appropriate under the circumstances.

VI. SUBROGATION & REIMBURSEMENT

As a condition to the receipt of benefits under this article, a person agrees: (1) to reimburse the Plan the portion it is due for benefits paid on account of any illness, injury, or condition for which an employer or other third party (or their respective insurers) may be liable, regardless of whether such recovery is less than the actual loss suffered by the person, to the extent any benefit payments are recovered from the proceeds of any judgment, settlement, payment or otherwise, and irrespective of whether responsibility is accepted or denied by an employer or other third party; (2) to waive any argument or contention that any action by the Trustees in state court is pre-empted by federal law; and (3) to assign to the Trustees the person's right of action against the employer or other third party (or their respective insurers) to the extent benefits have been paid or may be paid in the future. In addition, any person eligible for benefits must, in order to receive any benefits and to maintain eligibility under the Plan, (i) notify the Trustees of the Plan within thirty (30) days after making a claim against an employer or other third party (or their respective insurers) relating to an incident leading to damages, benefits and/or other compensation, of the fact and nature of such claim; (ii) furnish any information or assistance and execute any documents that the Trustees may require; and (iii) take no action that may prejudice or interfere with such rights.

Whether or not the preceding requirements are satisfied, the Trustees shall (1) be automatically assigned such person's right of action against the employer or other third party (or their respective insurers) to recover benefits that have been paid or may be paid in the future; (2) have the right to intervene at any time in any action brought against an employer or other third party (or their respective insurers) to recover all benefits that have been paid or may be paid in the future; (3) be reimbursed fully from the proceeds of any judgment, settlement, payment or other resolution of any action or proceeding, including from the estate of any covered person, to recover benefits that have been paid or may be paid in the future, regardless of whether the total amount of such recovery is less than the actual loss suffered by the person; (4) be reimbursed 100% of the charges it paid in a lump sum at the time payment is received by a covered person, his or her Dependents, or his or her representative; and (5) have an automatic first lien upon any recovery to the extent of benefits that have been paid or in the future may be paid. In all five instances set forth above in this paragraph, the Trustees shall have such rights regardless of whether the total amount of such recovery is less than the actual loss suffered by the person. The Trustees shall also be fully reimbursed for any charges paid in error, whether the error was that of the Plan, participant or Dependent.

If any person does not comply with any of the foregoing requirements, the Trustees may suspend that person's ongoing eligibility for benefits and deny pending or future claims until such time that he or she is in compliance with such requirements. Specifically, if any Participant or Dependent enters into any settlement of his/her claim(s) pursuant to state workers' compensation law or personal injury law (whether or not a lawsuit is filed) that does not include complete and final resolution of the Plan's lien, claim for reimbursement and/or subrogation claim immediately upon effectuation of such settlement, the Plan may suspend the person's ongoing eligibility for benefits and deny pending or future claims until the Plan has recouped an amount equal to the value of such claims. Such recoupment may be accomplished via processing of medical benefit claims without payment of the amounts normally payable under the Plan.

The Plan expressly disavows the application of legal theories such as the "collateral source", the "make-whole" doctrine and the "common fund" doctrine to the extent that they may prevent or limit the Plan's recovery from any payment a person with eligibility receives from a third party (or its insurer). The Plan's reimbursement will not be reduced to pay any portion of the attorneys' fees and costs associated with the person's legal recovery.

The information in this section applies to any no-fault insurance recoveries and all proceedings and actions, including but not limited to proceedings under any state workers' compensation acts, and any actions for negligence, medical malpractice, products liability, and other torts or wrongful acts.

Subrogation and Reimbursement for HMO Benefits. Rules similar to those set forth above in this section shall apply to individuals covered under one of the HMOs to the extent provided in the applicable HMO contract.

VII. COORDINATION OF BENEFITS

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, your health plan provides a Coordination of Benefits ("COB") provision. This provision affects all of your health coverages.

A. HOW COORDINATION OF BENEFITS WORKS

If you or your Dependents are also covered under another group plan, the total amount received from all plans will never be more than 100% of the "Allowable Expenses." Benefits are reduced only to the extent necessary to prevent any person from making a profit.

"Allowable Expenses" are any Reasonable and Customary expenses for medical or dental services, treatment or supplies covered by one or more of the plans under which you or your Dependents are covered.

A "plan" is considered to be any group plan providing coverage for medical treatments or services on an insured or uninsured basis. This includes labor-management trustee plans, union welfare plans, employer organization plans, any coverage under government programs and any coverage required or provided by law, including Mandatory State No-Fault Auto Insurance.

This Coordination of Benefits provision shall not apply to any private coverage that you or your Dependents purchase individually.

B. WHICH PLAN PAYS FIRST

1. If both plans have Coordination of Benefits provisions, the plan that insures you as a member pays first.

2. If you are insured as a member under two plans, the plan which has insured you longer is the primary. However, if you are insured as an Active member under one plan and a laid-off employee or Retiree under another plan, the plan that insures you as an Active member will pay its benefits first; this does not apply if either plan does not have a provision regarding laid-off or retired members.

3. If one plan does not have a Coordination of Benefits provision, that plan is always primary.

4. If a Dependent Child is covered under two plans, the plan of the parent whose birthday occurs earliest in the year will pay benefits first.

5. If the parents are divorced or are separated, the plan of the parent with custody pays benefits first.

6. In the event of qualified joint custody, the plan of the parent whose birthday occurs earliest in the year will be the primary.

7. If the parent with custody remarries, the "order of payment" is as follows:

- **(a)** Natural parent with whom child resides,
- **(b)** Stepparent with whom child resides,
- **(c)** Natural parent not having custody of the child.

This order of payment can change if the divorce decree child support order directs one of the parents to be financially responsible for the medical, dental or other health care expenses of the child.

C. COORDINATION WITH MEDICARE

Coverage under this Plan will be Secondary if you are eligible for Medicare and you are a retired member or a Dependent of a retired member.

1. **When the Plan Is Primary.** If you are eligible for Medicare and you are either: (a) actively employed and over age 65; or (b) the spouse/Domestic Partner of an actively employed person and over age 65, coverage under this Plan will be primary. In each case, where this Plan continues as the primary carrier, the Trust will pay first and Medicare will pay second. However, you and your spouse/Domestic Partner have the option of electing Medicare as primary. Please note: If Medicare is elected as primary, coverage under this Plan will cease as required by Federal Law.

2. **When You Are Entitled to Medicare Due to Total Disability.** You or your Dependent may become entitled to Medicare benefits prior to age 65 due to total disability or end stage renal disease. The following rules apply with respect to COB with Medicare due to total disability or end stage renal disease prior to age 65. Upon attainment of age 65, the rules for COB with Medicare at age 65 apply.

   This Plan will be a primary plan to Medicare during any waiting period for Medicare benefits due to total disability or end stage renal disease. After the Medicare waiting period has been met, and you or your Dependents are entitled to Medicare benefits, this Plan will be:

   (a) a Primary plan to Medicare for an Active member, or his or her Dependent, who is entitled to Medicare benefits due to total disability for other than end stage renal disease; and

   (b) a Secondary plan to Medicare for an Active member, or his or her Dependent, who is entitled to Medicare benefits due to end stage renal disease.

   If you are eligible for Medicare due to ESRD, you must apply to receive full benefits because enrollment for Medicare benefits is not automatic. If you do not enroll in Medicare as soon as you are eligible, the Plan will not cover the portion of your expense that Medicare would have paid.

3. **Right to Obtain or Release Information.** The Plan may obtain or release any information necessary to implement these provisions. You must declare your coverage under other group plans. The Plan can pay to another paying organization amounts warranted to satisfy the intent of this provision and, to the extent of such payment, be discharged from liability for that claim.

   The Plan can also recover amounts that are overpaid under this provision from the member, from an insurance company, or from another organization. Information necessary to the administration of this provision will be required of you at the time a claim is submitted. Payment of the claim may be delayed if the required information is not provided.

D. COORDINATION WITH MEDICAID

Benefits payable by this Plan will be made in compliance with any assignment of rights made by or on behalf of such Eligible Individual as required by California's plan for medical assistance approved under Title XIX, Paragraph 1912(a)(1)(A) of the Social Security Act (Medicaid).

If the State has provided medical assistance (under Medicaid) where this Plan has a legal liability to make payment for such services, payment will be made by this Plan for claims submitted within one year from the date expenses were incurred.

E. COORDINATION WITH PREPAID PLANS

Regardless of whether this Plan may be considered primary or secondary under its coordination of benefits

provisions, in the event you or your Dependent:

1. has coverage under the indemnity portion of this Plan, and

2. has coverage under a prepaid program (as hereafter defined) under another group plan (regardless of whether you or your Dependent must pay a portion of the premium for such plan), and

3. incurs expenses normally covered under the prepaid program, then this Plan will only reimburse the co-payments required of you or your Dependents under the prepaid program, and only if such co-payments are required of every person covered by that program.

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

VIII. IMPORTANT LAWS THAT AFFECT YOUR BENEFITS

A. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT
Special Rights Upon Childbirth

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or her newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours if applicable). In any case, plans may not, under federal law, require that the provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

B. WOMEN'S HEALTH AND CANCER RIGHTS ACT
Special Rights Concerning Mastectomy Coverage

Under federal law, group health plans that provide coverage for mastectomies are also required to provide coverage for reconstructive surgery and prostheses following mastectomies. Specifically, the law mandates that a Participant or eligible beneficiary who is receiving benefits for a covered mastectomy and who elects breast reconstruction in connection with a mastectomy, will also receive coverage for the following:

1. Reconstruction of the breast on which the mastectomy has been performed;

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

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

This coverage will be provided in consultation with the patient and the patient's attending Physician and is subject to the same annual deductible, coinsurance and/or co-payment provisions otherwise applicable under the Plan. If you have questions concerning your coverage, please call the Plan Office.

C. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Special Rights Concerning Health Information

1. **Privacy and Security.** This section explains the Plan's use and disclosure of health information protected by HIPAA. Protected health information ("PHI") is individual identifiable health information that is maintained or transmitted by the Plan, subject to some exceptions. Individually identifiable health information is health information: (i) that is created or received by a health care provider, health plan, employer or health care clearinghouse; (ii) that is related to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you; and (iii) with respect to which there is a reasonable basis for believing that the information can be used to identify you. PHI also includes genetic information (such as family medical history and information about an individual's receipt of genetic services or genetic tests). PHI that is transmitted electronically is "Electronic PHI." The Plan is a "Hybrid Entity" under HIPAA because it provides health benefits and non-health benefits. The privacy and security rules apply only to health benefits.

The Plan will use PHI and Electronic PHI only to the extent, and in accordance with, the uses and disclosures related to health care treatment, payment for health care and health care operations. The Plan will also use and disclose PHI and Electronic PHI as required by law and as permitted by authorization. "Payment" involves Plan activities to obtain premiums or determine or fulfill coverage or benefit

responsibilities including, but not limited to, eligibility determinations, enrollment, coordination of benefits, claims adjudication, subrogation, employee contributions, risk adjusting, billing, collection (including reports to consumer reporting agencies related to collection), claims management and related data processing, obtaining payment under a reinsurance contract, reviews of medical necessity, care or charges, and utilization review. "Health care operations" include, but are not limited to, quality assessment, population-based activities to improve health or reduce health care costs, protocol development, case management, care coordination, disease management, communication regarding treatment alternatives, rating providers, rating plan performance, accreditation, certification, licensing, credentialing activities, underwriting, premium rating, creation, renewal or replacement of insurance including reinsurance, stop-loss and excess loss insurance, medical reviews, obtaining legal or auditing services, fraud and abuse detection, business planning, development and management, compliance with HIPAA administrative simplification, customer service, internal grievance resolution and compliance with ERISA (including preparation of required documents, such as Forms 5500 and SARs).

The Plan will disclose PHI to the Board of Trustees only pursuant to an authorization or for Plan administration after receipt of a certification from the Board of Trustees that this document contains these provisions. Any Trustee that does not comply with these provisions will receive appropriate sanctions. With respect to PHI and Electronic PHI, the Board of Trustees agrees to:

- not use or further disclose the information other than as permitted or required by the Plan document or law;
- ensure that any agents, including the Plan Office, to whom the Board of Trustees provides PHI and Electronic PHI agree to these restrictions and conditions;
- not use or disclose the information for employment-related actions or decisions unless the use or disclosure is pursuant to an authorization;
- not use or disclose the information in connection with any other benefit or employee benefit plan unless the use or disclosure is pursuant to an authorization;
- report to the Plan any use or disclosure of the information that the Board of Trustees is aware of and that is inconsistent with the allowable uses and disclosures;
- make PHI and Electronic PHI available to the individual, for amendment, or for an accounting of non-routine disclosures in accordance with the requirements of HIPAA;
- incorporate amendments to PHI and Electronic PHI in accordance with HIPAA;
- make internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI received from the Plan available to the Secretary of Health and Human Services for the purpose of determining the Plan's compliance with HIPAA;
- ensure that the adequate separation between the Plan and the Board (i.e., the firewall), required by 45 CFR §504(f)(2)(iii) is established; and
- if feasible, return or destroy all PHI and Electronic PHI received from the Plan (or copies) when the information is no longer needed; if not feasible, limit further use or disclosure to the purposes that make the return or destruction infeasible.

  The Board of Trustees further agrees that if it creates, receives, maintains, or transmits any Electronic PHI (other than information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR §164.508, which are not subject to these restrictions) on behalf of the Plan, it will:

- implement administrative, physical, and technical safeguards that reasonably and appropriately

protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- ensure that the firewall required by 45 CFR §504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and
- appropriately address any security incident of which it becomes aware.

2. **Compliance with the Genetic Information Nondisclosure Act of 2008.** We note that in accordance with federal law, the Plan does not intend to use or disclose genetic information for underwriting purposes.

D. AFFORDABLE CARE ACT
Patient Protections

1. **Provider Choice**: You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members. For Dependent Children, you may designate a pediatrician as the primary care provider.

2. **Obstetrical & Gynecological Care**: You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in your 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.

3. **Emergency Services**: No prior authorization is required for emergency services. Out-of-network emergency services will be covered at the same level as in-network emergency services.

IX. INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

A. NAME AND TYPE OF ADMINISTRATION OF THE PLAN

The name of the Plan is IBEW Local 595 Health & Welfare Plan. The Plan is administered and maintained by the Joint Board of Trustees under contract with the fund management firm:

BeneSys Administrators
IBEW Local 595 Health & Welfare Plan Fund Manager
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

(925) 208-9996 or (888) 512-5863

B. INTERNAL REVENUE SERVICE PLAN IDENTIFICATION NUMBER

The Employer Identification Number (EIN) issued to the Board of Trustees is 94-6085740.
The Plan Number is 501.

C. TYPE OF PLAN

The Plan is a health care plan providing for the following benefits: Medical, Dental, Vision, Member Assistance Program, Group Life Insurance and Accidental Death & Dismemberment benefits, Long-Term Disability Program and Drug-Free Workplace Program to eligible Active Employees, Retirees and their Dependents. Note that the Drug-Free Workplace Program is described in a separate booklet available in the Plan Office.

D. COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained pursuant to a Collective Bargaining Agreement and Declaration of Trust negotiated by IBEW Local 595 and the Northern California Chapter of the National Electrical Contractors Association. Each appoints an equal number of trustees to the Joint Board of Trustees of the IBEW Local 595 Health & Welfare Plan. The Board of Trustees is the Plan Administrator and the named Fiduciary with the authority to control and manage the operations and administration of the Plan. Its telephone number at BeneSys Administrators is as follows: (925) 208-9996.

A copy of the Collective Bargaining Agreement may be obtained upon 10 days' advance written request to the Plan Office.

E. NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS

Board of Trustees
c/o BeneSys Administrators
Fund Manager
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

(925) 208-9996

Service of legal process may be made upon any member of the Joint Board of Trustees. Names and addresses of the current Board members are contained on page i.

F. REQUIREMENTS REGARDING ELIGIBILITY FOR PARTICIPATION AND BENEFITS

The Plan's requirements with respect to eligibility for benefits are shown in Section II of this document.

G. SOURCE OF FINANCING OF THE PLAN

With the exception of voluntary self-payment by Participants electing to extend coverage during COBRA continuation coverage periods, all contributions to the plan are made by individual Employers in accordance with collective bargaining agreements described in Section XI.D, above. A complete list of such Employers may be obtained by eligible Employees upon 10 days' advance written request to the Plan Office. The Trustees may impose a reasonable charge for the list.

H. IDENTITY OF ORGANIZATIONS THROUGH WHICH BENEFITS ARE PROVIDED

The organizations through which benefits are provided are:

1. Delta Dental Plan
2. United Healthcare Dental
3. Anthem Blue Cross (PPO Network)
4. Kaiser Foundation Health Plan/Kaiser Senior Advantage
5. United Healthcare/United Healthcare Secure Horizon/United Healthcare Senior Supplement Plan (eff. February 2015, United Healthcare Medicare Advantage National PPO)
6. Optum Behavioral Health
7. Vision Services Plan
8. Anthem Blue Cross (Case Management)
9. Optum Rx

I. METHOD OF FUNDING

The programs of the Plan are financed through the Plan, which is funded by contributions of Employers and Employees and investment income, if any. Employers contribute to the Welfare Plan at rates determined by applicable Collective Bargaining Agreements between Local 595 and the Northern California Chapter of the National Electrical Contractors Association. As described in this booklet, Employees are able to self-pay for certain periods of time when they are not covered by employer contributions.

J. CLAIM AND APPEAL PROCEDURES

The procedures for filing claims and appealing claim details are set forth in Appendix A of this booklet.

K. PLAN YEAR

The fiscal year of the Plan is the twelve-month period ending each January 31st, and the Plan's records are maintained on that basis.

L. PLAN BENEFITS ARE NOT GUARANTEED

The benefits provided by this Plan, while intended to remain in effect indefinitely, can be guaranteed only so long as the parties to collective bargaining agreements continue to require contributions into the Trust sufficient to underwrite the cost of the benefits. The Trustees reserve the right to amend this Plan Document and to modify benefits at any time, or to reduce or eliminate benefits if necessary to maintain the financial soundness of the Plan. The benefits of the Plan, including both Active and Retiree coverage are not guaranteed lifetime benefits.

X. STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA and subsequent amendments. ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Office and at Local Union, 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.

2. Obtain, upon written request to the Board of Trustees or the Plan Office, 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. A reasonable charge may be made for these copies.

3. Receive a summary of the Plan's annual financial report. The Plan Office is required by law to furnish each Participant with a copy of this summary financial report.

4. Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under this plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage.

5. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

If your claim for welfare benefits is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to obtain copies of documents relating to the decision without charge and appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request certain materials required to be furnished by the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay 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 frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XI. DEFINITIONS

These are some of the terms used in your booklet. Some other terms are described where they are used. **PLEASE READ THEM CAREFULLY**. They can help you to better understand what your benefits are.

Active member means all persons who are Employees of a Contributing Employer, or who are otherwise entitled to participate in the Plan or to maintain Plan participation.

Authorized Individuals means Plan Trustees, the Fund Manager, officers, employees or other persons under the control of the Trustees or the Fund Manager who perform Plan-related functions.

Board of Trustees or Trustees means the Board of Trustees established by the IBEW Local 595 Health & Welfare Trust Agreement.

Calendar Year means the twelve-month period beginning January 1 and ending December 31. (Note: the Plan Year is the twelve-month period beginning February 1 and ending January 31.)

Complications of pregnancy means:

- Conditions that require hospital confinements (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, or which are caused by pregnancy; and
- Non-elective Cesarean section; ectopic pregnancy which is terminated; and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Convalescent Hospital or Skilled Nursing Facility means an institution which:

- is regularly engaged in providing skilled nursing care for sick and injured persons under 24-hour supervision of a Physician or a graduate Registered Nurse (R.N.);
- has available at all times the services of a Doctor who is a staff member of a general Hospital;
- has on duty 24 hours a day a graduate Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or skilled practical nurse;
- has a graduate Registered Nurse (R.N.) on duty at least 8 hours per day;
- maintains a daily medical record for each patient; and
- complies with all licensing and other legal requirements.

Convalescent Hospital does **not** mean any institution, or part thereof (other than incidentally), which is a place for rest, a place for Custodial Care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or a similar institution.

Covered Charge(s) or Covered Expense(s) means only those charges which are Reasonable and Customary and which are incurred as a result of a Medical Necessity for conditions that are covered under this Plan. It shall also mean only those charges incurred by a Covered Person while eligible for benefits under this Plan. In no event shall a Covered Expense exceed the lesser of the Reasonable and Customary Charges billed by a health care provider or the contractual rate for such expense under a Preferred Provider Agreement and this Plan or between a health care provider and the plan with which this Plan is coordinating.

Covered Employee or Employee means a member performing work under a Collective Bargaining Agreement with IBEW Local 595 or Local 595 Motor Shop which requires contributions to this Plan or employee for whom contributions are made to this Plan pursuant to a subscription agreement approved by the Board of Trustees.

Covered Employment means work performed under a Collective Bargaining Agreement with a Local Union of IBEW which requires contributions to this Plan.

Covered Person or Participant means each eligible Covered Employee or Retiree and each of his or her Dependents, if any.

Custodial Care means treatment, services or confinement which could be rendered safely and reasonably by a person not medically skilled, and which is designed mainly to help the patient with activities of daily life. Custodial Care includes personal care, homemaking services, moving the patient, acting as companion or sitter, or supervising medication which can usually be self-administered.

Dependent means lawful spouse, Domestic Partner, or a Child under 26 years of age.

Doctor or Physician means a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) authorized to perform medical or surgical service within the lawful scope of his or her practice, and shall also include any other health care provider or allied practitioner as mandated by State Law.

Employer or Contributing Employer means an Employer who makes contributions to this Plan on behalf of Covered Employees.

Experimental or Investigational Measures mean any treatment or service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of medicine, as determined by the Claims Administrator.

Generally Accepted means treatment or service that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- is in general use in the medical community; and
- is not under continued scientific testing or research as a therapy for the particular injury or sickness which is the subject of claim.

Health Insurance Issuer means an insurance company, insurance service or insurance organization that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. This does not include a group health plan.

Health Maintenance Organization means a public or private entity which is organized under the laws of any state and which provides basic and supplemental health services to its members. An HMO uses a group of Physicians and other health care professionals (also called network providers) who emphasize preventive care and early intervention.

Hospital means an institution which:

- is primarily engaged in providing, by or under the supervision of Doctors, in-patient diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or rehabilitation of injured, disabled or sick persons;
- maintains clinical records on all patients;
- has bylaws in effect with respect to its staff of Doctors;
- has a requirement that every patient be under the care of a Physician;
- provides 24-hour nursing service rendered or supervised by a registered professional nurse;
- has in effect a Hospital utilization review plan;

- is licensed pursuant to any state or agency of the state responsible for licensing Hospitals;
- has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals

The term "Hospital" does not include an institution, or that part of an institution, used mainly for: (1) nursing care; (2) rest care; (3) convalescent care; (4) care of the aged; (5) Custodial Care; or (6) educational services.

IBEW Local 595 Pension Plan is the defined benefit IBEW Local 595 Pension Plan, which is wholly distinct from the IBEW Local 595 Money Purchase Plan.

Illness means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same causes.

Injury means physical harm sustained to the body as the direct result of an accident, affected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

Loss of hand or foot means that the limb is severed at or above the wrist or ankle joint.

Loss of sight means the total and irreversible loss of sight.

Medically Necessary means the treatment must be ordered by a Doctor or other Licensed or Certified Health Care Provider to diagnose or treat an Injury or Illness and be:

- generally recognized as effective and essential to the treatment of the Injury or Illness for which it is ordered;
- appropriate for the symptoms and consistent with the diagnosis;
- the appropriate level of care, and which: (i) is provided in the most appropriate setting, based on the diagnosis and condition; and (ii) could not have been omitted without an adverse effect on the Covered Person's condition or the quality of medical care;
- based on generally recognized and accepted standards of medical practice in the United States;
- not considered experimental, investigatory, or primarily limited to research in its application to the Injury or Illness;
- not primarily for scholastic, educational, vocational or developmental training; and
- not primarily for the comfort, convenience or administrative ease of the Doctor or other health care provider, or the member or his or her family or care taker;
- not Custodial Care.

Medicare means the benefits provided under Title XVIII of the Social Security Amendments of 1965.

Other Licensed or Certified Health Care Provider means Physician's assistant, nurse practitioners or midwife, or nurse midwife, who provides medical care within the scope of their license or certificate.

Plan is used interchangeably with the term "Trust Fund" throughout this document and means the IBEW Local 595 Health & Welfare Plan.

Plan Office means the administrative office of the IBEW Local 595 Health & Welfare Plan in Pleasanton, California.

Prescription Drugs means any article that may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act including any amendments thereto, only upon a written or oral prescription of a Physician or Dentist licensed by law to administer it.

Preventive Care means items or services required to be covered without cost-sharing (copayment or coinsurance charge when delivered by an in-network provider. A comprehensive list of Preventive Care health services can be found at www.HealthCare.gov/center/regulations/prevention.html and additional information regarding the U.S. Preventive Services Task Force recommended services receiving grades A or B is located at www.uspreventiveservicetaskforce.org.

If a Preventive Care item or service is billed separately from an office visit, the office visit may not be treated as a Preventive Care Covered Charge. If a Preventive Care item or service and office visit are not billed separately and the primary purpose of the office visit is the delivery of the Preventive Care item or service, the office visit will be treated as a Preventive Care Covered Charge; but if the delivery of the Preventive Care item or service is not the primary purpose of the office visit, the office visit may not be treated as a Preventive Care Covered Charge. A Preventive Care item or service may not be treated as a Preventive Care Covered Charge until the first day of the Plan year beginning on or after the date on which the service or treatment is designed as a Preventive Care item or service.

Protected Health Information ("PHI") is individually identifiable health information (including demographic information collected from an individual), that is created or received by a health care provider, health plan, Employer or health care clearinghouse; relates to the past, present or future payment for the provisions of health care to an individual, and identifies the individual or could reasonably be used to identify the individual. PHI is transmitted by or maintained in electronic media or any other form or medium.

Reasonable and Customary means a charge which falls within the common range of fees billed by a majority of health care providers for a covered procedure in a given geographic region, or which is justified based on the complexity or the severity of treatment for a specific case, as determined from time to time by the Board. In no event does it mean a charge in excess of the general level of charges made by others who rendered or furnished such services, treatments or supplies to persons: (a) who reside in the same area; and (b) whose illness is comparable in nature and severity. The term "area" means a county or such greater area that is necessary to obtain a representative cross paragraph of the usual charges made. Currently the Plan uses Context 4 at the 90th percentile to determine what is Reasonable and Customary. This means that the acceptable limit will not exceed the amounts normally charged by 90% of the Doctors in a geographical area.

Review Organization or Independent Review Organization ("IRO") means an organization, under contract to the Fund, which is responsible to determine whether the elective confinement of an Eligible Individual to a Hospital is Medically Necessary, and if Medically Necessary, to determine the number of Medically Necessary days for such confinement solely for the purpose of determining whether such Eligible Individual is to receive unreduced benefit coverage according to the terms of the Plan for Covered Expenses incurred as a result of such Hospital confinement.

Summary Health Information means information that may be individually identifiable health information and summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under group health plan and from which the information has been deleted except the individual's five-digit zip code.

Trust Agreement means the Trust Agreement establishing the IBEW Local 595 Health & Welfare Plan and any modification, amendment, extension or renewal thereof.

Union means the International Brotherhood of Electrical Workers, Local 595 that has entered into a collective bargaining agreement with an Employer, the terms of which require such Employer to make contributions to the IBEW Local 595 Health & Welfare Plan on behalf of eligible Employees, Retirees and their Dependents.

APPENDIX A
IBEW Local 595 Health & Welfare Trust
CLAIM AND APPEAL PROCEDURE

I. INTERNAL CLAIMS AND APPEALS PROCEDURES

No Participant or other beneficiary will have any right or claim to benefits under the Plan or from the Plan, except as specified in the Trust Agreement. Any dispute as to eligibility, type, amount or duration of benefit under the Plan or any amendment or modification thereof will be resolved by the Board of Trustees under and pursuant to the Plan and the Trust Agreement. No action may be brought for benefits provided by the Plan or any amendment or modification thereof, or to enforce any right thereunder, until after the claim therefor has been submitted to and determined by the Board of Trustees.

The internal claims and appeals procedure described below will apply to claims and appeals over which the Board of Trustees has discretion, solely for benefits covered under the Self-Funded Indemnity Plan and the Additional Deductible Indemnity Medical Plan. Except for questions of eligibility under the Plan, the Board of Trustees does not have any say over benefit determinations made by an HMO or other Provider or insurance carrier. Claims for benefits under such arrangements must be pursued using the claims and appeals procedures provided by such HMO, Provider or insurance carrier. **In other words, DO NOT USE THE IBEW LOCAL 595 HEALTH & WELFARE PLAN CLAIMS FILING AND APPEALS PROCEDURES if you are enrolled in a Plan option other than the Self-Funded Indemnity Plan and the Additional Deductible Indemnity Medical Plan.** Instead, for such claims, please read the provider's Evidence of Coverage or Insurance Policy for the claims and appeals procedure applicable to the benefit.

IMPORTANT NOTE: In all cases, provisions under the HMO provider and the Self-Funded Indemnity Plan procedures require that claims for benefits or reimbursement for medical services and appeals from the denial of claims must be submitted within a specific period of time. A failure to meet these time limits may bar the claim or appeal. Study the following and any additional brochures from HMOs and other providers for additional details regarding the making of a claim or the taking of an appeal.

A. FILING A CLAIM

You or your authorized representative may file a claim for benefits covered under the Self-Funded Indemnity Plan and the Additional Deductible Indemnity Medical Plan by contacting the Plan Office. The Plan Office will provide you with further instructions for filing your claim. The Plan may also require you to provide an authorization certifying that you have authorized another individual to act on your behalf (i.e., your "authorized representative") in pursuing a claim or appeal.

Claims must be filed at the Plan Office within twelve (12) months following the first day of care, otherwise benefits will be payable only for the period, if any, beginning (12) months prior to the date when the claim is filed. The Board of Trustees may, at their discretion, extend the above time limit in the event evidence is produced in a form satisfactory to the Board that it was not reasonably possible to furnish timely proof.

1. **Types of Claims.** Upon receipt of your claim, the Plan will categorize the claim as a Pre-Admission Certification, Post-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, or a Disability Claim. The categorization of your claim will dictate the Plan's time frame for responding to your claim. Please note that most of your claims will be Post-Service Claims.

    (a) **A Pre-Admission Certification** is required for all hospitalizations in order for you and your eligible Dependents to have Plan benefits paid at the maximum level. This program does not apply if this Plan is the secondary payer of benefits. In addition, it applies only to in-patient admissions and not to outpatient services. Pre-Admission Certification is provided through

Anthem Blue Cross. Prior to a Hospital confinement, you or your Doctor must contact Anthem Blue Cross at (800) 274-7767.

(b) **An Urgent Care Claim** is any claim for medical care or treatment where the application of the time periods for making non-urgent care determinations:

(i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(ii) would, in the opinion of a Physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the claimed care or treatment.

You may make a verbal request to the Review Organization (Anthem Blue Cross) for determination on an Urgent Care Claim or submit an Urgent Care Claim in writing to Anthem Blue Cross. A Physician or other health care professional who has knowledge of your medical condition may act as your authorized representative. Such Physician or health care professional need not be certified as your "authorized representative."

You may be asked to explain or describe whether and what medical circumstances exist that may give rise to a need for expedited processing of your claim, i.e., what medical circumstances exist that make your claim an Urgent Care Claim.

(c) **A Concurrent Care Claim** is a claim for ongoing care or treatment plan that has been reviewed and approved by Anthem Blue Cross. An example would be physical therapy or chiropractic care for which a treatment program would include a limited number of visits.

Once you or your Dependent have entered the Hospital, following the Pre-Admission Certification, Anthem Blue Cross will continue to monitor your stay to determine the appropriate length of confinement and the necessity of medical services. If Anthem Blue Cross concludes that your hospitalization is unnecessary, you and your Doctor will be notified. A Concurrent Claim that involves a reduction or termination (other than by plan amendment or termination) of previously approved benefits will be made by Anthem Blue Cross as soon as possible, but in any event early enough to give you time to have an appeal decided before the benefit is reduced or terminated.

(d) **A Post-Service Claim** is any claim that is not a Pre-Admission Certification claim. This includes a Rescission of Coverage Claim. If your coverage is retroactively cancelled or discontinued for a reason other than your failure to make required payments, you may submit a Rescission of Coverage Claim to the Plan for review.

(e) **A Disability Claim** is a request for benefits where the Plan must make a determination of disability to decide the claim. This includes a rescission of disability coverage. If your coverage is retroactively cancelled or discontinued for a reason other than your failure to make required payments, you may submit a Rescission of Disability Coverage Claim to the Plan for review.

2. **Notification of Grant of Benefits.** For Pre-Admission Certification and Urgent Care Claims, you will receive notification of your benefit approval. The notices will contain sufficient information to fully apprise you of the Plan's decision to approve the requested benefit(s). For Urgent Care Claims, the notification will be made orally, followed by a written confirmation.

3. **Time Frames for Initial Decision-Making.**

(a) **Pre-Admission Certification Claims.** If you have a Pre-Admission Claim and Anthem Blue Cross denies your claim in whole or in part, you will be notified in writing of the denial in

the form of an Explanation of Benefits within **15** days after receipt of your claim, unless circumstances beyond the control of Anthem Blue Cross require an extension of time. If an extension is required, you will be given written notice of the extension prior to the termination of the initial **15**-day period. The extension will not exceed **15** days from the end of the initial period.

In the event that an extension is necessary because you failed to submit information necessary to decide your claim (including the report of a required medical examination), your written notice of the extension will specifically describe the required information. The time period for making a benefit decision will also be suspended until the earlier of the Plan's receipt of all the requested information or the date established by the Plan for the furnishing of the information (**45** days or other longer period specified in the Plan's notice). A decision will be made on your claim within **15** days after you respond to the request for additional information or within **15** days after the end of the deadline given to provide additional information, whichever is earlier.

If your claim for Pre-Admission Certification is improperly filed, Anthem Blue Cross will notify you as soon as possible, but not later than 5 days after receipt of your claim, of the proper procedures to be followed in filing a claim.

(b) **Urgent Care Claims.** In emergency cases, Anthem Blue Cross must be notified within 48 hours or within 2 business days after your Hospital admission.

Any Urgent Care Claim that requests to extend a course of treatment beyond the initially prescribed period of time or number of treatments will be decided by Anthem Blue Cross within 24 hours of receipt of the claim, provided that the claim is made at least 24 hours prior to the expiration of the initially approved period. A request to extend approved treatment that does not involve urgent care will be decided according to the applicable Pre-Admission Certification or Post-Service Claims time frames.

If you properly submitted an Urgent Care Claim with all the necessary information, Anthem Blue Cross will provide you with written notice of its benefit determination as soon as possible, taking into account medical needs, but not later than **72** hours after the Plan's receipt of your claim. However, if you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Plan will notify you within **24** hours after the Plan's receipt of your claim of the specific information necessary to complete your claim. You must provide the specified information within **48** hours (or any longer period specified in the Plan's notice). Thereafter, the Plan will notify you of the Plan's benefit determination no later than **48** hours after the earlier of the Plan's receipt of the specified information, or the end of the period given to you to provide the specified additional information.

If you fail to follow the procedure for filing an Urgent Care Claim, you will be notified of the failure and the proper procedures to be filed as soon as possible, but not later than **24** hours after the Plan's receipt of the improper claim. You may be notified orally, in which case a confirmation letter will be sent in writing within three days of the oral notice. You will receive a notice if the claim or your communication to the Plan fails to include any of the following information: (i) the name of the specific claimant, (ii) the specific medical condition or symptom, and (iii) the specific treatment, service, or product for which Plan approval is requested.

(c) **Concurrent Care Claims.** If Anthem Blue Cross approved an ongoing course of treatment to be provided over a period of time or number of treatments and there is a reduction or termination of the course or number of treatments before the end of the period of time or number of treatments, Anthem Blue Cross will notify you sufficiently in advance of the reduction or termination to allow you to appeal the decision before the benefit is reduced or terminated.

Effect on Plan Benefits: In the event that you do not obtain Pre-Admission Certification and Concurrent Review for all hospitalizations, the benefits that would have been paid will be reduced by 10% under the Self-Funded Indemnity Plan and the Additional Deductible Indemnity Medical Plan. This reduction does not apply to the out-of-pocket maximum.

(d) **Post-Service Claims.** If you submitted a Post-Service Claim and the Plan Office denies your claim in whole or in part, the Plan Office will provide you with written notice of the Plan's benefit determination in the form of an Explanation of Benefits within **30** days of the Plan's receipt of your claim, unless circumstances beyond the control of the Plan Office require an extension of time. If an extension is required, you will be given written notice of the extension prior to the termination of the initial **30**-day period. The extension will not exceed **15** days from the end of the initial period.

In the event that an extension is necessary because you failed to submit information necessary to decide your claim (including the report of a required medical examination), your written notice of the extension will specifically describe the required information. The time period for making a benefit decision will also be suspended until the earlier of the Plan's receipt of all the requested information or the date established by the Plan for the furnishing of the information (**45** days or other longer period specified in the Plan's notice). A decision will be made on your claim within **15** days after you respond to the request for additional information or within **15** days after the end of the deadline given to provide additional information, whichever is earlier.

(e) **Disability Claims**. If you submitted a Disability Claim and the Plan Office denies your claim in whole or in part, the Plan Office will provide you with written notice of the Plan's benefit determination within **45** days of the Plan's receipt of your claim, unless circumstances beyond the control of the Plan Office require an extension of time. If an extension is required, you will be given written notice of the extension prior to the termination of the initial **45**-day period. This period may be extended for up to **30** days from the end of the initial period. If prior to the end of the first 30-day extension, the Plan determines that its decision cannot be rendered within the extension period due to circumstances beyond its control the period to make a determination may be extended by an additional **30** days. The Plan will provide you with written notice prior to the expiration of the first **30**-day extension explaining the standards on which entitlement to a benefit is based, the unresolved issues preventing a decision on the claim, and the additional information needed to resolve those issues.

If the claim is incomplete because additional information is needed, you will be given at least **45** days or other longer period specified in the Plan's notice to provide the specified information. A decision will be made on your claim within **45** days after you respond to the request for additional information or within **45** days after the end of the deadline given to provide additional information, whichever is earlier.

4. **Notification Requirements for an Initial Claim.** If your claim for benefits under the Self-Funded Indemnity Plan and the Additional Deductible Indemnity Medical Plan is denied in whole or in part, the Plan Office will provide you with a notice of the adverse determination that includes the following information:

(a) the specific reason or reasons for the adverse determination;

(b) reference to the specific plan provision(s) on which the determination is based;

(c) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;

(d) a description of the Plan's appeal procedure and the time limits applicable to

such procedures;

(e) a statement regarding your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal and any available external review processes;

(f) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request;

(g) if the denial is based on a Medical Necessity or Experimental Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(h) information sufficient to identify the claim, including the date of service, the health care provider, and the claim amount. Diagnosis and treatment codes and their meanings will be provided upon request. (Effective February 1, 2012.)

If your Urgent Care Claim is denied, the notice will also include a description of the Plan's Expedited Internal Appeal procedure.

If your Disability Claim is denied, in addition to the notice requirements outlined above, the notice will be written in a culturally and linguistically appropriate manner, and will include:

(a) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented to the Plan of health care professionals treating you or vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination or not; and (3) the Social Security Administration disability determination presented by you to the Plan, if any;

(b) In the event that no internal rule, guideline, protocol, or other similar criterion under Section I.C.(4)(g) exists, the Plan will provide a statement notifying the Claimant of the lack of existence; and

(c) That upon request you will have reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits free of charge.

B. FILING AN INTERNAL APPEAL

If you disagree with the Plan's determination of your Claim, you may appeal the determination to the Board of Trustees. You may request such a review by sending a letter to the Board of Trustees within **180** days of receiving the denial notice. If you are appealing a denial of an Urgent Care Claim, you may submit your request for review to the Board of Trustees orally or in writing. As with the decision-making on the initial claim, the time frames for responding to your appeal will depend on the categorization of your claim as a Pre-Admission Certification Claim, an Urgent Care Claim, a Concurrent Care Claim, a Post-Service Claim, or a Disability Claim.

You will have continued Plan coverage pending the outcome of an eligibility claim or appeal submitted for review under these procedures. However, should your appeal be denied, you will be responsible for any benefits, including any costs incurred or premiums paid on your behalf, provided by the Plan during the pendency of your appeal.

1. Time Frames for Decision-Making on Appeal.

(a) **Urgent Care Claims.** If your appeal involves an Urgent Care Claim, all necessary information, including the Board of Trustees' decision, will be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method no later than **72** hours after the Plan's receipt of your appeal.

(b) **Pre-Admission Certification Claims.** If you submitted an appeal of a denied Pre-Admission Certification Claim, the Plan will notify you of its decision no later than **30** days after the Plan's receipt of your appeal.

(c) **Post-Service Claims.** If you submitted an appeal of a denied Post-Service Claim or an appeal of a reduction or termination of a previously approved course of ongoing treatments or number treatments, the Board of Trustees will notify you of its determination on appeal as soon as possible, but not later than **5** days after the next regularly scheduled Board of Trustees meeting, unless the appeal is filed less than **30** days before the next meeting. In such case, the Board of Trustees will notify you no later than **5** days after the second Board meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, the Board will notify you of its determination no later than **5** days after the third meeting of the Board following the Plan's receipt of the request for review. The Board of Trustees will 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.

(d) In the event your denied Claim involves a medical condition for which the timeframe for completion of an Expedited Internal Appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an Expedited Internal Appeal, the Plan shall waive the Internal Appeal determination and proceed to Expedited External Review (see Appendix A, Section II.D).

(e) **Disability Claims.**

If you submitted an appeal of a denied Disability Claim, the Board of Trustees will notify you of its determination on appeal as soon as possible, but not later than **5** days after the next regularly scheduled Board of Trustees meeting, unless the appeal is filed less than **30** days before the next meeting. In such case, the Board of Trustees will notify you no later than **5** days after the second Board meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, the Board will notify you of its determination no later than **5** days after the third meeting of the Board following the Plan's receipt of the request for review. The Board of Trustees will 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.

Before issuing an adverse benefit determination on review, the Plan will provide the Claimant, free of charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim, and any new or additional rationale that will be a basis for the denial. Such evidence and rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination is required so as to give the Claimant a reasonable opportunity to respond prior to that date.

2. Additional Rights on Appeal. If you choose to pursue an appeal, you will have the following rights:

(a) You will have the opportunity to submit written comments, documents, records, and other

information relating to your claim to the Board of Trustees/Claims Administrator;

(b) You will have the opportunity to request reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits free of charge. (Note: A document is considered relevant to the claim if it: (i) was relied upon in making the benefit determination; (ii) was submitted, considered or generated in the course of making the benefit determination, without regard as to whether it was relied upon in making the decision; and (iii) demonstrates compliance in making the benefit decision with the requirement that the benefit determination must follow the terms of the Plan and be consistent when applied to similarly situated claimants.);

(c) The appeal will take into account all comments, documents, records, and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) The reviewer, i.e., the Board of Trustees will consider the full record of the claim and will independently make a determination;

(e) The appeal will be conducted by a named fiduciary who is neither the individual who made the initial adverse determination, nor the subordinate of such individual;

(f) If the denial 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 named fiduciary will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment;

(g) The health care professional consulted on appeal will not be the individual consulted in connection with the initial denial nor the subordinate of any such individual; and

(h) You may request the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial denial, without regard to whether the advice was relied upon in making the benefit determination.

(i) If a denial is based on new or additional rationale or new or additional evidence, you will be provided with the rationale or evidence free of charge as soon as possible and sufficiently in advance of any denial to give you a reasonable opportunity to respond to the rational or evidence.

You do not have the right to appear before the Board of Trustees personally. The Board of Trustees may authorize a hearing if it determines that a hearing would be of assistance in its deliberation.

3. **Notification Requirements for Denial on Appeal.** If the Board of Trustees denies your appeal, the Board will provide you with a notice of the adverse determination that includes the following information:

(a) the specific reason or reasons for the adverse determination;

(b) a reference to the specific plan provisions on which the benefit determination is based;

(c) a statement regarding your entitlement to request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;

(d) a statement of your right to bring an action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) and any available external review processes;

(e) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion; or a statement that

such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; and

(f) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(g) information sufficient to identify the claim, including the date of service, the health care provider, and the claim amount. Diagnosis and treatment codes and their meanings will be provided upon request. (Effective February 1, 2012.)

If the denial involves disability benefits, in addition to the notice requirements outlined above, the notice will:

(a) Describe any applicable contractual limitations period that applies to your right to bring an action under section 502(a) of the Employee Retirement Income Security Act of 1974;

(b) Include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (1) the views presented to the Plan of health care professionals treating you or vocational professionals who evaluated you; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Plan, without regard to whether the advice was relied upon in making the benefit determination or not; and (3) the Social Security Administration disability determination presented by you to the Plan, if any; and

(c) Provide either the specific internal rules, guidelines, protocols, standards or other similar criterion of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criterion of the Plan do not exist.

The Board of Trustees, as Plan Administrator, is vested with all powers necessary to enable it to review all appeals of adverse benefit determinations and to determine all questions that may arise thereunder, including, but not limited to, all questions relating to the eligibility of Participants to participate in the Plan, reciprocity contributions and the amount of any benefit to which a Participant, beneficiary, spouse or Dependent may become entitled to hereunder. In so acting, the Trustees shall have full and complete authority and discretion to construe, interpret and apply all provisions of the Plan. Specifically, the Trustees shall have full and complete authority and discretion to make any determinations or findings of fact regarding any claims and appeals of any benefit determinations. However, the Board shall not be responsible for the denial of any benefit offered by the Plan by one of the providers contracting with the Plan where the denial of that benefit is not brought to the Board's attention by the Participant or beneficiary in the manner described. The decision of the Board of Trustees shall be final and binding upon you, except to the extent that you may choose to pursue any rights provided for by ERISA Section 502(a) following an adverse benefit determination or appeal or where External Review is available.

C. PAYMENT OF CLAIMS

Benefits are payable to the eligible Employee or Retiree or Dependent, or in the case of Life Insurance and Accidental Death benefits, the designated beneficiary, provided however, that the Trustees, in their discretion, may pay such benefits to a Hospital or Physician furnishing services, supplies, care or treatment for benefits which are payable, or reimbursement to any person, including a Dependent, who has paid the Hospital or Physician for such services, supplies, care or treatment. Such payments will constitute a full discharge of the liability of the Trustees and Plan to the extent of the benefits so paid.

D. DEEMED EXHAUSTION

Effective February 1, 2012, if the Plan does not strictly adhere to all the requirements regarding Internal Claims and Appeals Procedures under the Affordable Care Act, you are deemed to have exhausted these procedures and may request an External Review (see Appendix A, Section II.D) or pursue any other remedies under Section 502(a) of the Employee Retirement Income Security Act. You will not be deemed to have exhausted the Internal Claims and Appeals Procedure if the Plan's noncompliance (1) was *de minimis*; (2) does not cause (and is not likely to cause) you prejudice or harm; (3) was for good cause or due to matter beyond the Plan's control; (4) occurred in the context of an ongoing, good faith exchange of information between you and the Plan; and (5) was not part of a pattern or practice of noncompliance by the Plan. Within 10 days of a written request, the Plan will provide an explanation of the violation and any of the above exceptions that may apply.

In the case of a claim for disability benefits, if you choose to pursue remedies under section 502(a) of the Act, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

If an external reviewer or a court rejects your request for External Review because one of the above exceptions applies, you may resubmit your Claim and pursue an Internal Appeal. Within 10 days of an external reviewer's or a courts' rejection of your request for immediate review, the Plan will provide you with notice that you may resubmit your claim and pursue an Internal Appeal. Time periods for re-filing your claim will begin on the date you receive notice from the Plan. (If a court rejects your request for immediate review because one of the above exceptions applies, the claim shall be considered as re-filed on appeal upon the plan's receipt of the court's decision.)

If you have any questions regarding the above procedures, please contact the Plan Office.

II. EXTERNAL CLAIMS AND APPEALS PROCEDURES

If you disagree with an adverse Internal Claim or Appeal decision that involves either:

(1) medical judgment (including, but not limited to, judgments based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit) as determined by the external reviewer; or

(2) a rescission of coverage,

you may request an External Review. The External Review is conducted by an accredited Independent Review Organization ("IRO").

A. FILING FOR EXTERNAL REVIEW

You may file a request for External Review with the Board of Trustees within four (4) months after your receipt of the Internal Appeal decision. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth (5th) month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

B. PRELIMINARY REVIEW

Within 5 business days following the date of receipt of the External Review request the Trustees, or the Plan Office as its designee, must complete a preliminary review of the request to determine whether it is eligible for External Review. In order to be eligible for External Review the following factors must be met:

1. You are or were covered under the Plan at the time the health care item, service, or other benefit was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item, service, or other benefit was provided;

2. The adverse benefit determination or the adverse Internal Appeal determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

3. You have exhausted the Plan's Internal Appeal process unless you are not required to exhaust the Internal Appeals process under the federal interim final regulations; and

4. You have provided all of the information and forms required to process an External Review.

Notice of Preliminary Review: Within one (1) business day after completion of the Preliminary Review, the Trustees will issue a notice in writing to you. If the request for External Review is complete, but your claim is not eligible for External Review, such notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, such notice will describe the information or materials needed to make the request complete, and the Plan will allow you to provide the needed information or materials within the later of the four-month filing period or within 48 hours following your receipt of the Notice of Preliminary Review.

C. EXTERNAL REVIEW BY INDEPENDENT REVIEW ORGANIZATION

The Plan has assigned an accredited IRO to conduct External Reviews and has taken action, in compliance with federal law, to protect against bias and to ensure independence in these reviews.

1. Upon receipt of the External Review, the IRO will:

   (a) utilize legal experts where appropriate to make coverage determinations under the Plan;

   (b) timely notify you in writing of the request's eligibility and acceptance for external review;

2. Within five (5) business days after the date of assignment to the IRO, the Trustees must provide to the IRO any documents and any information considered in making the adverse benefit determination or the adverse Internal Appeal determination. Failure by the Plan to provide documents must not delay the External Review. If the Plan fails to timely provide the documents and information, the IRO may terminate the External Review and make a decision to reverse the adverse benefit determination or the adverse Internal Appeal determination. Within one (1) business day after making such decision, the IRO must notify you and the Trustees.

3. Upon receipt of any information submitted by you, the IRO must within one (1) business day forward such information to the Trustees. Upon receipt of any such information, the Trustees may reconsider the adverse benefit determination or adverse Internal Appeal determination that is the subject of the External Review. Any reconsideration by the Trustees must not delay the External Review. External Review may be terminated if the Trustees determine during reconsideration to reverse the previous determination and provide coverage or payment as requested by you. The Trustees will provide written notice to the IRO and you of its reversal of the previous determination within one (1) business day of such reversal. Thereafter, the IRO will terminate the External Review proceedings.

4. The IRO will review all information and documents timely received and review the claim and all evidence de novo. The IRO is not bound by any decisions or conclusions reached during the initial benefit determination or the Internal Appeal. In addition to the documents and information provided, the IRO will consider the following, as it determines appropriate, in reaching an External Review decision:

   (a) your medical records;

(b) the attending health care professional's recommendation;

(c) reports from appropriate health care professionals and other documents submitted by the Plan, you, or your treating Provider;

(d) the terms of the Plan (unless contrary to applicable law);

(e) appropriate medical practice guidelines, including evidence-based standards;

(f) any applicable clinical review criteria developed and used by the Plan (unless contrary to the Plan or applicable law);

(g) the opinion of the IRO's clinical reviewer.

5. The IRO will provide written notice of the final External Review decision to you and the Trustees within 45 days after the IRO receives the request for External Review. The notice will include:

(a) a general description of the reason for the request for External Review, including sufficient information to identify the claim;

(b) the date the IRO received the assignment to conduct the External Review;

(c) the date of the IRO's final External Review decision;

(d) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;

(e) an explanation of the principal reason or reasons for the IRO's decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;

(f) a statement that the determination is binding except to the extent that other remedies may be available under federal law to either the Plan or you;

(g) a statement that judicial review may be available to you; and

(h) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act ("PHS") section 2793.

6. The IRO must maintain records of all claims and notices associated with the External Review for 6 years. An IRO must make such records available for examination by you, the Plan, or state or federal government oversight agency upon request unless such disclosure would violate state or federal privacy laws.

D. EXPEDITED EXTERNAL REVIEW

1. An Expedited External Review shall be undertaken when you have a medical condition that necessitates Expedited External Review because the timeframe for completion of the standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the adverse Internal Appeal determination concerns an admission, availability of care, continued stay, or health care item, service, or other benefit for which you received emergency services, but you have not been discharged from a Provider's facility, or you qualify under applicable federal law.
2. The Trustees shall immediately upon receipt of the request for the Expedited External Review, perform the Preliminary Review and shall complete such review as soon as possible without regard to the five (5) business days referred to above. Upon its determination of the Preliminary Review, the Trustees will immediately send the Notice of Preliminary Review.
3. Upon a determination that the request is eligible for External Review, the Trustees will assign an IRO and transmit or provide all required documents and information electronically or by telephone or facsimile or by any other available expeditious method.
4. The IRO must provide its final External Review decision and notice of such decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an Expedited External Review.
5. If the notice of the Expedited External Review decision is provided by the IRO other than in writing, then within 48 hours of the date such notice is provided, the IRO will provide written confirmation of the decision to you and the Trustees.

The final decision of the IRO will be binding on both you and the Plan. If the IRO's final decision requires payment of benefits in whole or in part, the Plan will provide benefits pursuant to the final decision without delay, but reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law and regulations.

APPENDIX B
IBEW Local 595 Health & Welfare Trust
Temporary COVID-19 ("Coronavirus") Extension Relief

On March 16, 2020, six Bay Area counties, including Alameda County, implemented "shelter-in-place" orders due to the novel coronavirus disease, COVID-19, pandemic ("Coronavirus"), directing all businesses that were not providing "essential" services to close. In addition to posing serious risks to the health and welfare of Plan members and their families, this public health crisis and sheltering orders significantly impacted the construction industry, resulting in work shortages and layoffs in Covered Employment.

Effective March 2020, the Plan provided continuation coverage for May, June and July 2020, to Plan members if their Dollar Bank reserves had exhausted, and any of the following circumstances applied:

- Plan member lost Plan coverage because of workforce reductions, furloughs, or layoffs related to the Coronavirus; or
- Plan member was unable to work after testing positive for the Coronavirus; or
- Plan member declined work or was unable to work due to having or having been exposed to Coronavirus or were caring for family members who may have been at higher risk for severe illness.

The Buy Up payment requirement was waived for extended coverage months during May, June and July 2020.

Effective July 2020, the Plan provided full continuation coverage for the August 2020 coverage month, and 50% coverage for the remainder of the 2020 calendar year (September, October, November and December 2020), provided that the Plan member's Dollar Bank reserves had exhausted, and at least one of the circumstances listed above applied.

The Buy Up payment for August 2020 was waived. In order to have received the 50% Plan covered extended coverage months for September to December 2020 ("COVID 50% Subsidy"), Plan members must have submitted payment for 50% of the Buy Up amount.

Effective January 1, 2021, the Plan extended the COVID 50% Subsidy for January, February, March and April 2021, subject to the Plan member meeting the requirements listed above. Plan members are responsible for submitting payment for 50% of the Buy Up amount.

The Fund Office will send information to Plan members who exhaust their Dollar Bank reserves and consequently lose eligibility for coverage months of January, February, March, and/or April 2021, regarding the payment due to the Plan if they elect the COVID 50% Subsidy. Payments are due within 30 days from the date of the Plan's invoice.

The Fund Office will also send information regarding COBRA entitlement, which could be elected if the Plan member declines or fails to timely submit payment for the COVID Subsidy. Unlike COBRA continuation coverage, all months of extended eligibility provided to Plan members by the Board of Trustees due to the Coronavirus, including the COVID Subsidy coverage, have been deemed Active Coverage for Retiree Coverage crediting purposes under the Plan.

Individuals whose unemployment is voluntary or unrelated to the Coronavirus; or who work in non-Covered Employment for a non-signatory employer are ineligible for continued coverage under the temporary Coronavirus relief.