I.B.E.W. / NECA

SOUND AND COMMUNICATIONS

HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2005
# I.B.E.W. / NECA Sound and Communications
## Health and Welfare Plan

### Index

*Updated January 1, 2005*

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# I.B.E.W. / NECA Sound and Communications Health and Welfare Plan

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TRUSTEES’ LETTER

The Board of Trustees are pleased to issue this new Benefit Booklet, effective January 1, 2005, including all prior amendments. This Benefit Booklet serves as the Plan Document for the I.B.E.W./NECA Sound and Communications Health and Welfare Plan. The Plan includes Medical and Prescription Drug benefits either through the Self-Funded Plan or your selection of one of three (3) Health Maintenance Organizations (HMO’s). The Plan also includes Vision, Dental, Short Term Disability, Chemical Dependency, Life Insurance and Accidental Death and Dismemberment Insurance and Member Assistance Program benefits.

This Benefit Booklet summarizes the Plan’s requirements relating to:

1. Eligibility to participate in the various Self-Funded Plan benefits and/or HMO’s as described above;
2. The circumstances that may result in termination of eligibility to participate;
3. Conditions pertaining to eligibility to receive benefits from the Self-Funded Plan and/or HMO plans;
4. Appeal rights if your claim for a benefit is denied and;
5. Your rights under the Employee Retirement Income Security Act of 1974;

The benefits provided by the Self-Funded Plan are set forth in this benefit booklet. The benefits provided by the HMO’s; Health Net, Kaiser Permanente and PacifiCare of California, are described in separate informational booklets produced by each respective HMO.

The benefits provided by the I.B.E.W./NECA Sound and Communications Health and Welfare Plan are not vested benefits. Although the Board of Trustees intends to continue to provide health and welfare benefits for you and your family, the Board of Trustees reserves the right as it determines in its sole discretion to alter, modify or discontinue any or all of the benefits in the health and welfare plan. The Board of Trustees therefore reserves the right to amend, change or terminate any or all of the benefits described in this Plan Benefit Booklet, including the right to change the eligibility rules, change or reduce benefits or increase the amount of any self-payments.

You may change the medical program covering yourself and your eligible family members during the annual open enrollment period between November 1st and November 30th, for coverage change effective date of January 1st.

Regardless of the Medical and Prescription Drug Plan you choose, you and your dependents are eligible for Dental, Chemical Dependency, Vision and Member Assistance Program benefits. You are also eligible for Short Term Disability, Life Insurance and Accidental Death and Dismemberment benefits as described in this Benefit Booklet.

The Board of Trustees has discretionary authority to interpret all provisions of this Benefit Booklet, including but not limited to eligibility to participate in any of the Self-Funded benefits of the Plan as well as any HMO plan, eligibility for benefits and the amount of benefits, if any to be paid. No individual Trustee, Union Representative, Employer Representative or employee of the Fund Administrator is authorized to interpret this Benefit Booklet for the Board of Trustees. The Board of Trustees has authorized employees of the Fund Administrator to respond informally to you or your dependents written or oral inquiries on an informal basis. However, the written and oral answers are not binding upon the Board of Trustees.

For your convenience there is a Definition of Terms section located in the back of this Benefit Booklet. If you would like further information or assistance, please call or write the Fund Administrator:

I.B.E.W./NECA SOUND AND COMMUNICATIONS
HEALTH AND WELFARE PLAN
1120 S. Bascom Avenue
San Jose, CA 95128-3590

Telephone: (408) 288-4400
Toll-Free: (800) 541-8059
# I.B.E.W. / NECA Sound and Communications Health and Welfare Plan

## Labor Trustees

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Phone</th>
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<tbody>
<tr>
<td>Dan Chivello</td>
<td>I.B.E.W. Local No. 595, 6250 Village Parkway, Dublin, CA 94568-2449</td>
<td></td>
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<tr>
<td>John O'Rourke</td>
<td>I.B.E.W. Local No. 6, 55 Filmore Street, San Francisco, CA 94117-3545</td>
<td></td>
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<tr>
<td>Bob Tragni</td>
<td>I.B.E.W. Local No. 332, 2125 Canoas Garden Avenue, Suite #100, San Jose, CA 95125-1393</td>
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## Management Trustees

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
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<tbody>
<tr>
<td>Rick Jensen</td>
<td>JM Electric, 400 Griffin Street, Salinas, CA 93901-4344</td>
<td></td>
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<tr>
<td>Doug Lung</td>
<td>NECA – Santa Clara Valley Chapter, P.O. Box 28899, San Jose, CA 95159-8899</td>
<td></td>
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<tr>
<td>Ben Wadsworth</td>
<td>River City Communications Corp., 643 W. Stadium Lane, Sacramento, CA 95834-1100</td>
<td></td>
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<tr>
<td>Category</td>
<td>Information</td>
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<tr>
<td><strong>ELIGIBILITY, PREMIUMS, RESERVE AMOUNTS AND INFORMATION BOOKLETS</strong></td>
<td>United Administrative Services (Fund Administrator's Office) (408) 288-4452 Toll-Free: (800) 541-8059</td>
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<tr>
<td><strong>SELF-FUNDED MEDICAL AND DENTAL PLAN</strong></td>
<td>For questions about claim payment, claim forms and benefit information call: Fund Administrator's Office (408) 288-4481 Toll-Free: (800) 541-8059</td>
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<td><strong>BLUE CROSS PPO</strong></td>
<td><a href="http://www.bluecrossca.com">www.bluecrossca.com</a> &lt;br&gt;To locate a participating preferred provider physician, clinic or hospital call: (408) 288-4452 Toll-Free: (800) 541-8059 (Refer to Group # 170016)</td>
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<td><strong>INTERPLAN / DENTINEX DENTAL PPO</strong></td>
<td><a href="http://www.Interplancorp.com">www.Interplancorp.com</a> &lt;br&gt;To locate a participating preferred provider dentist call: Toll-Free: (800) 444-4036</td>
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<td><strong>KAISER PERMANENTE (HMO)</strong></td>
<td><a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a> &lt;br&gt;For questions about benefit information and ID Cards call: Toll-Free: (800) 464-4000 (Refer to Group # 919)</td>
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<td><a href="http://www.health.net">www.health.net</a> &lt;br&gt;For questions about benefit information and ID Cards call: Toll-Free: (800) 522-0088 (Refer to Group # 57845)</td>
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<td><strong>PACIFICARE (HMO)</strong></td>
<td><a href="http://www.pacificare.com">www.pacificare.com</a> &lt;br&gt;For questions about benefit information and ID Cards call: Toll-Free: (800) 624-8822 (Refer to Group # 140167)</td>
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<td><strong>PACIFICARE BEHAVIORAL HEALTH</strong></td>
<td><a href="http://www.pbhi.com">www.pbhi.com</a> &lt;br&gt;For questions about mental health, chemical dependency and Member assistance program benefits call: Toll-Free: (877) 225-2267</td>
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<td><strong>VISION SERVICE PLAN</strong></td>
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ELIGIBILITY

CATEGORY 1 “BARGAINING UNIT” EMPLOYEE

Eligibility

A Category 1 employee works under a collective bargaining agreement between an employer and certain Local Unions of the I.B.E.W. Employers who have a collective bargaining agreement with certain Local Unions of the I.B.E.W. will pay the hourly contribution rate stipulated in the collective bargaining agreement to the Trust for each hour of service you have worked. All hours, for the purpose of calculating contributions, will be treated as straight-time hours.

All employers contributions for work you have performed are credited in dollars to your Reserve Account up to a maximum balance of $5,890 (9 months). Your Reserve Account cannot accumulate more than that amount. This is a continuing process. You may contact the Fund Administrator to determine the dollars in your Reserve Account.

You and your eligible dependents will be covered on the first day of the second month following the last day of any month in which you have accumulated a reserve of $650 and if contributions have been made and received in your name for the hours you have worked for one or more participating employers.

On the first day of the calendar month for which you are covered, $650 is deducted from your reserve accumulation for one (1) month of coverage. The $650 deduction covers Medical, Prescription Drug, Dental, Vision, Short Term Disability, Life Insurance, Accidental Death and Dismemberment and Member Assistance Program benefits.

You may use your reserve accumulation to extend certain coverages while you are unemployed or working insufficient hours to equal the $650 monthly requirement.

To become eligible and to maintain coverage, you must accumulate a sufficient balance (in dollars) in your Reserve Account in any qualifying month to meet the required charge in the corresponding coverage month for one month’s coverage, as shown in the chart below.

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CATEGORY 2 “NON-BARGAINING” EMPLOYEE

Eligibility

A NECA employer contributing to the Trust for regular employees “Category 2”, may include by executing, one month in advance of initial coverage, a “non-bargaining subscription / participation agreement” that allows coverage for non-bargaining employees subject to the following rules and regulations:

1. Contributing employers under a Collective Bargaining Agreement with an I.B.E.W. Local Union and who are NECA members, may elect to cover their employees not covered by a Collective Bargaining Agreement, but must cover all such employees if there are less than 5 employees in this Category.
ELIGIBILITY

Employers with more than 5 employees must cover 80% in this Category. “Employee” does not include the spouse of an owner, unless the spouse is performing bargaining unit work.

2. Employers electing to cover Category 2 employees must cover newly hired Category 2 employees the first of the month following completion of ninety (90) days of continuous full-time employment by paying the applicable monthly contribution for such coverage in advance. “Full time” means at least eighty (80) hours per month or equivalent pay period.

3. Contributing employers not electing to cover their Category 2 employees initially may thereafter apply on each successive anniversary date of the Plan, which is January 1st of each year, to enroll their Category 2 employees. All applications and payments must be in the Fund Administrator’s Office by December 15th and thereafter the monthly charge for this group must be paid in advance each month to the Fund Administrator. Acceptance of Category 2 contribution payments is subject to Trustee audit and compliance with the foregoing. An employee may be required to provide satisfactory evidence of good health to the Board of Trustees.

4. Non-Bargaining Unit Employees do not have a reserve dollar bank accumulation but are eligible for all benefits under this Plan except the Short Term Disability Benefit.

5. The Trustees shall establish the monthly payment required for Category 2 participants from time to time. The amount of this monthly payment may be obtained by contacting the Fund Administrator’s Office.

6. Employers electing to cover their non-bargaining unit employees must sign a written subscription/participation agreement acknowledging the above rules and agreeing to be bound by the terms of the Trust Agreement for the I.B.E.W. / NECA Sound and Communications Health and Welfare Plan, and specifically to comply with Trust rules concerning compliance with payroll audits and assessment of liquidated damages and other costs if contribution payments are not received on time.

Termination of Coverage

Coverage for yourself and your Dependents will terminate:

1. On the last day of any month in which your account has less than the minimum reserve; or

2. On the last day of any month in which you fail to maintain the minimum reserve because your employer failed to pay the required contributions; or

3. On the last day of the calendar month in which you enter military service.

The coverage for a Dependent will terminate when the Dependent ceases to be an eligible Dependent.

PARTIAL SELF-PAYMENTS

Any participant who loses coverage under this plan due to delinquent payment of contributions by a signatory employer shall be eligible to make self-payments to this Plan for a period not to exceed four (4) months at a rate equal to that charged participants eligible to make payments pursuant to COBRA. In the event the participant’s employer ceases being signatory to an I.B.E.W. Local Union Collective Bargaining Agreement the right to self-pay under this provision shall automatically terminate.

A partial self-payment is equal to the difference between the amount in your Reserve Account and the required monthly deduction. There must be no lapse in coverage, and you must have had coverage in the month immediately preceding the month for which you want to make a partial self-payment. The prior month’s coverage must not have been provided through COBRA self-payment. If you do not make a partial payment to continue coverage, you will not be eligible to make future self-payments until your Reserve Account has enough employer contributions to pay for a month’s coverage, except as set forth under the Continuation of Coverage rules as outlined in this Benefit Booklet. You must make the required self-payment by the 10th day of the month for which you are self-paying the premium. Such payments shall be payable to the I.B.E.W./NECA Sound and Communications Health and Welfare Plan and remitted to the Fund Administrator.
ELIGIBILITY

REQUIREMENTS TO MAKE A PARTIAL SELF-PAYMENT OR USE YOUR RESERVE ACCOUNT

To be eligible to make a partial self-payment or use your Reserve Account to obtain benefits you must be:

1. Employed by a NECA contributing employer who is signatory to an I.B.E.W. Local Union Collective Bargaining Agreement; or

2. Available for immediate dispatch to a contributing employer by being registered on the appropriate Local Union’s out-of-work list; or

3. Working for a NECA employer contributing to another trust that is a party to a reciprocity agreement with the I.B.E.W./NECA Sound and Communications Health and Welfare Plan; or

4. Eligible to receive, currently receiving or have received an I.B.E.W. Pension, not working in the electrical industry, or disabled.

If you fail to qualify under one or more of the above paragraphs for twelve (12) consecutive months, at the end of the twelfth 12th month your Reserve Account will be forfeited and revert to the unallocated reserves of the Trust.

IF YOU ARE OUT OF WORK

As long as you maintain a Reserve Account balance and comply with one of the preceding paragraphs 1., 2., 3., or 4. above, your benefits will be continued.

If you fail to maintain a sufficient reserve in your dollar bank but then return to work and accumulate the required amount, your benefits will be automatically reinstated as of the first day of the coverage month corresponding to the qualifying month as previously described.

UTILIZATION OR FREEZING OF RESERVE BANK

Upon leaving covered employment a participant having reserve hours to his or her credit under this Plan will have the option of:

1. Running out his or her reserve dollar bank account, or;

2. Serving written notice to the Board of Trustees subsequent to leaving covered employment of his or her desire to freeze his or her reserve dollar bank account for a period not to exceed one year.

This option is for the purpose of avoiding duplicate primary coverage of the participant which would result in unnecessary utilization of their reserve account while primary coverage through another I.B.E.W. health and welfare plan exists. This option is not available unless the participant, upon leaving covered employment becomes a participant in another I.B.E.W. health and welfare plan.

The freezing of reserve hours will become effective on the 1st day of the calendar month beginning subsequent to the date of serving said notice, provided said notice is received by the Plan Manager prior to the 20th of the month. If received after the 20th of the month the freezing will become effective on the 1st day of the second following calendar month.

Upon re-entry into covered employment within the one year period from date of serving of the above notice, said participant shall be allowed thirty (30) days within which to file notice of their intention to unfreeze their reserve account.

It is further provided that such unfrozen reserve account shall be reassigned effective the first day of the second month after said participant has returned to covered employment or is available for immediate employment under coverage of this plan.

Reserve dollar banks amounting to less than the required amount for one month of coverage may not be frozen.
ELIGIBILITY

IF YOU MOVE FROM ONE CONTRIBUTING EMPLOYER TO ANOTHER

Your benefits under this Plan will continue provided you have maintained the necessary reserve as of the first of each month. Should you transfer from one contributing employer to another, your Reserve Account will be maintained, and you will not lose any benefits. You should make sure your new employer is contributing to the Trust for you.

IF YOU CHANGE EMPLOYMENT FROM A CATEGORY 1 TO A CATEGORY 2 EMPLOYEE

If you are a Category 1 (bargaining-unit) employee and you change employment classification to a Category 2 (non bargaining) employee and have a Reserve Account balance, your accumulated reserve account will be frozen for a period of twelve (12) months. If no contributions are received on your behalf as a Category 1 (bargaining-unit) employee during the twelve (12) months your Reserve Account has been frozen, any dollars remaining in your Reserve Account will be forfeited and revert to the unallocated reserves of the Trust.

DEATH OF EMPLOYEE

Upon the death of any employee who has eligible dependents covered under the Plan, such dependents shall continue to be eligible for benefits until the deceased employee’s reserve dollar bank account is exhausted. Your dependents are eligible for continuation coverage under COBRA as defined within the COBRA - Continuation of Coverage section of this benefit booklet.

THE MAXIMUM ACCUMULATION IN YOUR RESERVE ACCOUNT

The maximum amount you are allowed to accumulate in your Reserve Account is $5,890 (9 months) after your monthly deduction as set by the Board of Trustees.

To check on your Reserve Account each month, contact the Fund Administrator:

United Administrative Services
1120 S. Bascom Avenue
San Jose, CA 95128-3590

Telephone: (408) 288-4452
Toll Free: (800) 541-8059

RECIPROCAL AGREEMENTS

The I.B.E.W./NECA Sound and Communications Health and Welfare Plan is a party to the Electrical Industry Health and Welfare Reciprocal Agreement. If you would like to have your health and welfare contributions sent from the I.B.E.W./NECA Sound & Communications Health & Welfare Plan to your home fund or from the health fund where you are working to the I.B.E.W./NECA Sound & Communications Health & Welfare Plan, contact the Fund Administrator for instructions.

Effective January 1, 2003, all participants must utilize the "Electrical Reciprocal Transfer System (ERTS)" to change reciprocity. You must register on ERTS to participate in reciprocity. For assistance, contact your home I.B.E.W. Local Union or the Fund Administrator.

An election to transfer your contributions to another health fund will act as a release and waiver of any and all claims against the I.B.E.W./NECA Sound and Communications Health and Welfare Plan once contributions have been transferred and receipted by the health fund of your designation.

If the contribution rate of the funds to which your contributions are transferred is less than the contribution rate of the I.B.E.W./NECA Sound and Communications Health and Welfare Plan, the smaller amount will be transferred, and the contributions over and above that hourly rate (excess contributions) will be retained by the I.B.E.W./NECA Sound and Communications Health and Welfare Plan. By electing transfer, you waive any claims
ELIGIBILITY

that might otherwise be made based on the retention by the I.B.E.W./NECA Sound and Communications Health and Welfare Plan of these excess contributions.

Eligibility to reciprocate funds shall be governed by the terms and conditions of the Electrical Industry Health and Welfare Reciprocal Agreement.

NOTIFICATION OF CHANGE OF ADDRESS

From time to time the Fund Administrator may wish to communicate with you in writing in order to inform you of any changes in the Plan adopted by the Board of Trustees, or to obtain information related to your benefits under the Plan or concerning administration of the Plan.

It is your responsibility to notify the Fund Administrator in writing on any change of address. The Plan and Board of Trustees cannot be held liable for failing to provide written notification if you change your address and do not notify the Fund Administrator in a timely manner.
SELF-PAYMENT

COBRA CONTINUATION COVERAGE RIGHTS

THIS SECTION IS APPLICABLE TO ALL EMPLOYEES AND THEIR DEPENDENTS REGARDLESS OF WHETHER YOU ARE ENROLLED IN THE SELF-FUNDED MEDICAL PLAN, PACIFICARE PLAN, HEALTH NET PLAN OR THE KAISER FOUNDATION HEALTH PLAN.

Introduction

This section of the booklet contains important information about your right to COBRA continuation coverage, which is a temporary extension of medical and prescription drug coverage or medical, prescription drug, dental and vision coverage. The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and your Dependents who are covered under this Plan or an HMO (PacifiCare, Health Net or Kaiser) when you would otherwise lose your group health plan coverage. This section explains COBRA continuation coverage, when it may become available to you and your Dependents, and what you need to do to preserve your right to COBRA continuation coverage.

The I.B.E.W. / NECA Sound and Communications Health and Welfare Plan offers no greater COBRA rights than what the COBRA statute requires, and this section of the benefit booklet shall be construed accordingly.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of group health plan coverage that would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. The Fund Administrator is responsible for determining whether a qualifying event has occurred. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose group health care coverage under the Plan or an HMO (PacifiCare, Health Net or Kaiser) because of a qualifying event. Depending on the type of qualifying event, Employees, spouses of Employees, and Dependent children of Employees, who are enrolled in the Plan or an insured plan (PacifiCare, Health Net or Kaiser), at the time of the qualifying event may be qualified beneficiaries. Certain newborns, newly adopted children and alternate recipients under Qualified Medical Child Support Orders may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage as described below.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under this Plan or an HMO (PacifiCare, Health Net or Kaiser) because either one of the following qualifying events happen:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason.

If you are the spouse of an Employee, you will become a qualified beneficiary if you will lose your coverage under this Plan or an HMO (PacifiCare, Health Net or Kaiser) because any of the following qualifying events happen:

1. Your spouse dies;
2. Your spouse’s hours of employment are reduced;
3. Your spouse’s employment ends for any reason;
4. Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse. If an Employee cancels coverage for his or her spouse in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse provides written notice to the Fund Administrator within sixty (60) days after the divorce or legal separation and can establish that the Employee canceled the coverage earlier in anticipation
SELF-PAYMENT

of the divorce or legal separation, then COBRA continuation coverage may be available for the period after
the divorce or legal separation.

Your Dependent children will become qualified beneficiaries if they will lose coverage under this Plan or an HMO
(PacifiCare, Health Net or Kaiser) because any of the following qualifying events happens:

1. The parent-Employee dies;
2. The parent-Employee’s hours of employment are reduced;
3. The parent-Employee’s employment ends for any reason;
4. The parent-Employee becomes entitled to Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child is no longer eligible for coverage because he or she no longer qualifies as a “Dependent child.”

Notices and Elections of COBRA Continuation Coverage

Under the self-funded plan of benefits, but not an HMO (PacifiCare, Health Net or Kaiser), your spouse’s
coverage ends the day that a divorce or legal separation occurs (coverage is lost for the spouse only). Under this
Plan and an HMO (PacifiCare, Health Net or Kaiser), a Dependent child’s coverage ends on the last day of the month
in which the Dependent child no longer qualifies as a Dependent.

Important: For the following qualifying events (divorce or legal separation of the Employee and spouse or a
Dependent child who no longer qualifies as a Dependent child), you, the spouse or Dependent child must notify the
Fund Administrator in writing within sixty (60) days after the divorce, legal separation or child losing Dependent status
using the procedures specified in the box below. If these procedures are not followed and the notice is not provided in
writing to the Fund Administrator during the sixty (60)-day notice period, any spouse or Dependent child who loses
coverage will NOT BE OFFERED THE OPTION TO ELECT COBRA CONTINUATION COVERAGE.

Notice Procedures: Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not
acceptable. You must mail or deliver your written notice to the Fund Administrator at this address:

I.B.E.W. / NECA Sound and Communications
Health and Welfare Plan
c/o United Administrative Services
1120 S. Bascom Avenue
San Jose, CA 95128-3590

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you
provide must state the name of the Plan (I.B.E.W. / NECA Sound and Communications Health and Welfare Plan), the
name and address of the Employee covered by the Plan and the names(s) and address(es) of the qualified
dependent(s) who will lose coverage due to a qualifying event. The notice must also state the qualifying event
(divorce, legal separation or child who no longer qualifies as a Dependent) and the date the qualifying event
happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

If the Fund Administrator receives timely written notice that one of the three qualifying events (divorce, legal
separation or child losing Dependent status) has happened, the Fund Administrator will notify the family member of
the right to elect COBRA continuation coverage. You, your spouse or Dependent child will also be notified by the
Fund Administrator of the right to elect COBRA continuation coverage automatically (without any action required by
you, your spouse or Dependent) when coverage is lost because your employment ends, reduction in hours, death or
enrollment in Medicare (Part A, Part B or both).

You, your spouse or Dependent must elect COBRA continuation coverage within sixty (60) days of receiving the
COBRA election form or, if later, sixty (60) days after coverage ends by completing and returning the election form to
the Fund Administrator. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. If
you, your spouse or your Dependent does not elect COBRA continuation coverage within the sixty (60) day
election period, you will lose your right to elect COBRA continuation coverage. The election to accept COBRA continuation coverage is effective on the date the election is mailed to the Fund Administrator. A qualified beneficiary may change a prior rejection of COBRA continuation coverage at any time until the election period expires.

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal law. You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a sixty-three (63) day gap in health coverage, and election of COBRA continuation coverage may help you avoid such a gap.

Benefits Available Under COBRA Continuation Coverage

You, your spouse and each Dependent child has the right to elect COBRA continuation coverage for medical and prescription drug coverage only, or for medical, prescription drug, dental and vision coverage. Any other benefits provided to you or your family by this Plan such as time loss benefits, life insurance and accidental death and dismemberment benefits are not available by electing COBRA continuation coverage. COBRA continuation coverage is identical to the medical, prescription drug, dental and vision coverage available to similarly situated Employees and Dependents. If the medical, prescription drug, dental and vision coverage is modified, COBRA continuation coverage will be modified in the same way.

How Long COBRA Continuation Coverage Lasts

COBRA continuation coverage is a temporary continuation of health and welfare coverage.

When the qualifying event is the death of the Employee, the Employee becoming entitled to Medicare benefits (Part A, Part B or both), divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to thirty-six (36) months.

When the qualifying event is the Employee’s termination of employment or reduction of the Employee’s hours of employment, and the Employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if an Employee becomes entitled to Medicare eight (8) months before the date on which his coverage terminates because of a reduction in hours, COBRA continuation coverage for his spouse and Dependent children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the Employee’s termination of employment or reduction of the Employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under this Plan or an HMO (PacifiCare, Health Net, or Kaiser) is determined by the Social Security Administration to be disabled and you notify the Fund Administrator in a timely fashion, you and your Dependents may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a maximum of twenty-nine (29) months. The disability would have to have started at some time before the sixtieth (60th) day of COBRA continuation coverage and must last at least until the end of the eighteen (18) month period of COBRA continuation coverage. You must make sure the Fund Administrator is notified in writing of the Social Security Administration’s disability determination within sixty (60) days after the date of the determination or the date of the qualifying event, if later, and before the end of the eighteen (18) month period of COBRA continuation coverage. You must follow the procedures specified in the box above, entitled “Notice Procedures.” In addition, your notice must include the name of the disabled person, the date that the qualified beneficiary became disabled and the date that the Social Security Administration made its determination. Your notice must also include a copy of the Social Security Administration’s disability determination. If these procedures are not followed or if the notice is not provided in writing to the Fund Administrator within the required period, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Fund Administrator of that fact in writing within thirty (30) days after the Social Security Administration’s determination.
Extension of 18-month period of continuation coverage due to second qualifying event

If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is timely given to the Fund Administrator. This extension may be available to the spouse and any Dependent children receiving COBRA continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child no longer qualifies as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under this Plan or an HMO (PacificCare, Health Net or Kaiser) had the first qualifying event not occurred. In all these cases, the spouse or Dependent child must make sure that the Fund Administrator is notified in writing of the second qualifying event within sixty (60) days of the second qualifying event. The spouse or Dependent child must follow the procedures specified in the box above, entitled “Notice Procedures.” Your written notice must state the second qualifying event and the date it happened. If the second qualifying event is a divorce, your notice must include a copy of the divorce decree. If these procedures are not followed or if the notice is not provided in writing to the Fund Administrator within the required sixty (60) day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.

How Much Does Continuation Coverage Cost?

A qualified beneficiary who elects COBRA continuation coverage may be required to pay the entire cost of COBRA continuation coverage. The cost may not exceed one hundred and two percent (102%) (or, in the case of an extension of COBRA continuation coverage due to a disability, one hundred and fifty percent (150%)) of the cost to the group health plan for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of sixty-five percent (65%) of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When and How Must Payment for COBRA Continuation Coverage be Made?

First Payment for COBRA continuation coverage

If you elect COBRA continuation coverage, you do not have to send a payment for COBRA continuation coverage with the election form. However, you must make your first payment for COBRA continuation coverage not later than forty-five (45) days after the date of your election. This is the date the election form is postmarked, if mailed. If you do not make your first payment for COBRA continuation coverage in full within forty-five (45) days after the date of your election, you will lose all COBRA continuation coverage rights.

Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under this Plan or an HMO (PacificCare, Health Net or Kaiser) would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment as well as monthly payments thereafter are enough to cover this entire period. You may contact the Fund Administrator to confirm the correct amount of your first payment.

Your first payment for COBRA continuation coverage should be sent to:

I.B.E.W. / NECA Sound and Communications
Health and Welfare Plan
c/o United Administrative Services
1120 S. Bascom Avenue
San Jose, CA 95128-3590
**Monthly payments for COBRA continuation coverage**

After you make your first payment for COBRA continuation coverage, you will be required to pay for COBRA continuation coverage for each subsequent month of coverage. These monthly payments are due by the first day of the month. If you make a monthly payment on or before the first day of the month, your coverage under the Plan will continue for that coverage period without any break. **The Plan will not send periodic notices of payment due for these coverage periods.**

Monthly payments for continuation coverage should be sent to:

I.B.E.W. / NECA Sound and Communications
Health and Welfare Plan
C/O United Administrative Services
1120 S. Bascom Avenue
San Jose, CA 95128-3590

**Grace periods for monthly payments**

Although monthly payments are due by the first day of the month, you will be given a grace period of thirty (30) days to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month, but before the end of the grace period, your coverage under this Plan or an HMO (PacifiCare, Health Net or Kaiser) will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you failed to make a monthly payment by the end of the grace period, you will lose all rights to COBRA Continuation Coverage.

**Termination of COBRA Continuation Coverage Before the End of the Maximum Period**

COBRA continuation coverage for you, your spouse or your Dependent children will automatically end (even before the end of the maximum coverage period) on the last day of the month in which any of the following events occur:

1. The premium is not paid within the grace period.
2. After electing COBRA continuation coverage, you, your spouse or Dependent child becomes enrolled in Medicare.
3. After electing COBRA continuation coverage, you, your spouse or Dependent child becomes covered under another group health plan (as an Employee or Dependent) that does not impose any pre-existing condition exclusion for a pre-existing condition. If the new group health plan has exclusions or limitations for pre-existing conditions, your COBRA continuation coverage will end after the exclusion or limitation period no longer applies. For example, after a six month waiting period, or under the federal law that requires portability of health care coverage (the Health Insurance Portability and Accountability Act of 1996), the pre-existing condition clause expires.
4. The I.B.E.W. / NECA Sound and Communications Health and Welfare Plan no longer provides group health coverage to any of its participants.
5. Your last employer no longer participates in the I.B.E.W. / NECA Sound and Communications Health and Welfare Plan and establishes one or more group health plans that covers a significant number of Employees who were formerly covered under the I.B.E.W. / NECA Sound and Communications Health and Welfare Plan or your last employer begins contributing to another multiemployer group health plan. In such a case, the new employer plan or multiemployer group health plan must assume the I.B.E.W. / NECA Sound and Communications Health and Welfare Plan’s COBRA continuation coverage obligation for you, your spouse and Dependent children.
Automatic COBRA Continuation Coverage for Your Spouse and Dependent Children in Certain Circumstances

When you elect COBRA continuation coverage, coverage for your spouse and your Dependent children will continue automatically unless your spouse independently declines COBRA continuation coverage. If you choose not to elect COBRA continuation coverage, your spouse and Dependent children may still elect COBRA continuation coverage. Of course, in all circumstances, anyone electing COBRA continuation coverage must pay the required premium.

Transfer Rights

If you are covered by an HMO (PacifiCare, Health Net or Kaiser Permanente) that covers a limited geographic area and relocate to another area where employers contributing to this Plan have an active workshop, you may be entitled to elect the self-funded plan of benefit coverage available to other Employees working in that area. If you find yourself in this situation, call or write the Fund Administrator. Under no circumstances would such a transfer prolong your maximum COBRA continuation coverage.

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered Employee during the COBRA period

A child born to, adopted by or placed for adoption with an Employee during a period of COBRA continuation coverage is considered to be a qualified beneficiary provided the Employee has elected COBRA continuation coverage for himself or herself. The child’s COBRA continuation coverage begins when the child is born and it lasts for as long as COBRA continuation coverage lasts for other family members of the Employee. To be enrolled in this Plan or an HMO (PacifiCare, Health Net, or Kaiser), the child must satisfy the otherwise applicable eligibility requirements (for example, regarding age.)

Alternate recipients under Qualified Medical Child Support Orders

A child of an Employee who is receiving benefits under this Plan or an HMO (PacifiCare, Health Net or Kaiser) pursuant to a Qualified Medical Child Support Order is entitled to the same rights under COBRA as a Dependent child of the covered Employee, regardless of whether that child would otherwise be considered a Dependent.

For More Information About COBRA Continuation Coverage

Questions concerning this Plan or an HMO (PacifiCare, Health Net or Kaiser) or your COBRA continuation coverage rights should be addressed to the Fund Administrator identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act and other laws affecting group health plans, contact the nearest Regional or District office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA offices are available through the website.

Keep the Fund Administrator Informed of Address Changes

The name, address and telephone number of the Fund Administrator is:

United Administrative Services
1120 S. Bascom Avenue
San Jose, CA 95128-3590
Phone: (408) 288-4452
Toll-Free: (800) 541-8059
SELF-PAYMENT

Conversion Privilege

At any time during the 18, 29 or 36 month COBRA Continuation of Coverage period, you may be entitled to enroll in an individual conversion plan provided by Health Net, Kaiser Permanente or PacifiCare of California provided your coverage has fewer benefits than your group health coverage.

California COBRA Extension

In the event you are age sixty (60) or over when your COBRA Continuation Coverage terminates, you may elect to extend your coverage until age sixty-five (65). This is known as CalCOBRA. Election of CalCOBRA coverage is done between you and your medical benefit provider; Kaiser Permanente, PacifiCare of California or Health Net. The I.B.E.W./NECA Sound and Communications Health and Welfare Plan does not provide the CalCOBRA coverage extension nor does it set the premium rates. If you are eligible for and want to elect CalCOBRA, you should contact your medical provider directly for information and any necessary forms required prior to your Trust provided COBRA Continuation Coverage ends.

Certificate of Former Coverage

If you or your Dependent(s) lose coverage under this Plan, you will be furnished with a certificate of former Plan coverage. You may need the certificate if your new group plan excludes coverage for pre-existing conditions. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage ends. You may also request a certificate within twenty-four (24) months after losing coverage under this Plan.

Military Service

If your eligibility terminates because of entry into the military service, you may continue eligibility through self-payments for up to eighteen (18) months. Upon release from active service your eligibility may be reinstated in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. If you are on military leave for less than thirty-one (31) days, your employer is required to pay for your medical coverage.

If your military leave begins on or after December 10, 2004, you will be eligible to continue coverage for up to twenty-four (24) months from the date military leave began provided you make monthly self payments of 102% of the cost of coverage. The other requirements stated above must also be met for coverage to continue.

Extended Coverage Under Family and Medical Leave Act

Your employer must continue to pay for your health coverage during any approved leave under the Federal Family and Medical Leave Act (FMLA). In general, you may qualify for up to twelve (12) weeks of unpaid FMLA leave per year if (1) your employer has at least fifty (50) Employees, (2) you worked for the employer for at least twelve (12) months and for a total of at least one thousand two hundred and fifty (1,250) hours during the most recent twelve (12) months, and (3) you require leave for one of the following reasons: (a) birth or placement of a child for adoption or foster care, (b) to care for your child, spouse or parent with a "serious health condition," or (c) your own "serious health condition." Details concerning FMLA leave are available from your employer.

A "serious health condition" is an illness, injury or impairment involving:

1. Inpatient treatment;
2. Absence from work or school for three or more days with continuing treatment by a health care provider;
3. Continuing treatment by a health care provider for a condition that is incurable or serious enough to result in three (3) or more days of incapacity; or
4. Prenatal care.
Requests for FMLA leave must be directed to your employer; the health plan cannot determine whether or not you qualify. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments. If the dispute is resolved in your favor, the health plan will obtain the FMLA-required contributions from your employer and will refund the corresponding COBRA payments to you.

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

The Benefit To Qualified Employees

If you qualify for this benefit as a Category 1 employee, your reserve account will be frozen at the end of the month that you leave work for the family and medical leave. The Trust will pay for up to three (3) months of health and welfare coverage. After three (3) months of Trust-paid coverage, you are responsible for payment of health and welfare coverage out of your Reserve Account or by COBRA payment.

If you qualify for this benefit as a Category 2 employee, your employer will pay the health and welfare premium for the month you last worked before taking the family and medical leave. The Trust then pays for up to three (3) months of health and welfare coverage. After three (3) months of Trust-paid coverage, health and welfare premiums must be paid by your employer or by COBRA payment.

Application Process

If you think you qualify for the family and medical leave and want to use this benefit, call the Fund Administrator to obtain an application form. You will need to complete the application form and return the completed application to the Fund Administrator. You will be notified whether you qualify for this benefit.

Trust-paid health and welfare coverage will stop before the third month if you return to work or otherwise terminate your family and medical leave.
SUMMARY OF BENEFITS

Below is a summary of the benefits provided by the Plan. Further explanation of the benefits may be found on the following pages and in the Kaiser, PacifiCare and Health Net brochures, which are available to you, upon request, from the Fund Administrator at no additional cost. Read this booklet carefully to determine the conditions under which these benefits are payable.

ACTIVE EMPLOYEES ONLY

Group Term Life Insurance (24-Hour Coverage) ................................................................. $15,000
Accidental Death & Dismemberment (24-Hour Coverage) ................................................... $15,000

The benefit level is reduced for participants age 70 or over as follows:

<table>
<thead>
<tr>
<th>Age</th>
<th>Percent of pre-age 70 benefit</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 – 74</td>
<td>65%</td>
<td>$9,750</td>
</tr>
<tr>
<td>75 or older</td>
<td>50%</td>
<td>$7,500</td>
</tr>
</tbody>
</table>

Short-Term Disability Benefit Amount

1st thirteen weeks ................................................................. $100 per week
2nd thirteen weeks ................................................................. $150 per week

Benefits begin on the first day for an accident or hospital confinement and on the eighth day in case of a non-hospital illness. The benefit covers non-occupational accidents or illness only.

SELF-FUNDED MEDICAL PLAN

FOR CATEGORY 1 AND 2 EMPLOYEES AND DEPENDENTS

Hospital-Medical-Surgical Expenses
80% of such Usual, Customary and Reasonable Charges each calendar year in excess of the $50 deductible amount for each eligible person.

Private Room Limit
The average semi-private room charge made in the hospital where the eligible person is confined.

Blue Cross PPO Contract Hospitals
For services rendered in a PPO Contract Hospital, the Plan will pay 90% instead of 80% of the first $2,500 of covered expenses each calendar year and 100% thereafter for the remainder of such calendar year. The $50 deductible will also be waived. A list of Contract Hospitals is provided to you automatically, free of charge, as a separate document.

Non-Contract Hospitals
The $2,500 stop-loss threshold does not apply to services rendered by a non-PPO hospital provider. Therefore, the Plan will pay 80% of all Usual, Customary and Reasonable Charges each calendar year in excess of the $50 deductible for services rendered by a non-PPO hospital provider even for expenses that exceed $2,500.

Maximum Lifetime Benefit
$1 million dollars for each eligible person.

Deductible Amount
$50 for all accidents and sickness applied once each calendar year for each eligible person. Maximum per family is $150.

Supplemental Accident Benefit
$500.

All of the above medical benefits are self-funded and are paid directly from Trust assets.
Instead of the Self-Funded benefits described above, you may elect medical coverage through Kaiser, PacifiCare or Health Net. Kaiser, PacifiCare and Health Net benefits are described in detail by Kaiser, PacifiCare and Health Net benefit brochures, which are available to you, upon request, from the Fund Administrator at no additional cost. Below is a summary of the benefits provided by Kaiser, Health Net and PacifiCare.

**CATEGORY 1 AND 2 EMPLOYEES AND DEPENDENTS**

**KAISER HMO PLAN**

<table>
<thead>
<tr>
<th>Services</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Copayment Limit</strong></td>
<td></td>
</tr>
<tr>
<td>For each member</td>
<td>$1,500</td>
</tr>
<tr>
<td>For each Family Unit</td>
<td>$3,000</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td>Allergy injection visits</td>
<td>No charge</td>
</tr>
<tr>
<td>Eye exams to provide a prescription for eyeglasses</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Hearing exams</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Immunizations</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>$10 per procedure</td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy visits</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Primary and specialty care visits for internal medicine, family practice, pediatrics, and gynecology (includes routine and urgent care appointments)</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Scheduled prenatal care and first postpartum visit</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Well-child preventive care visits (23 months or younger)</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>X-rays and lab tests</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Hospital Inpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital room and board, surgery, anesthesia, X-rays, lab tests, and medications</td>
<td>No charge</td>
</tr>
<tr>
<td>Skilled Nursing Facility (up to 100 days per benefit period)</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Covered items in accord with our formulary when obtained at Plan pharmacies:</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>50% Coinsurance up to a 100-day supply (or 3 cycles for oral contraceptives)</td>
</tr>
<tr>
<td>Brand name or compounded drugs</td>
<td>$25 up to a 100-day supply (or 3 cycles for oral contraceptives)</td>
</tr>
<tr>
<td>Drugs related to the treatment of sexual dysfunction disorders (episodic drugs are limited to 27 doses in any 100-day period)</td>
<td>50% Coinsurance up to a 100-day supply</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital inpatient care</td>
<td>No charge</td>
</tr>
<tr>
<td>Office visits</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Outpatient lab tests, X-rays, and special procedures</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>$10 per procedure</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient psychiatric care (up to 45 days per calendar year)</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient visits:</td>
<td></td>
</tr>
<tr>
<td>Up to a total of 20 individual and/or group therapy visits per calendar year</td>
<td></td>
</tr>
<tr>
<td>Individual therapy visits</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Group therapy visits</td>
<td>$5 per visit</td>
</tr>
</tbody>
</table>
### KAISER HMO PLAN, continued

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year</td>
<td>$5 per visit</td>
</tr>
</tbody>
</table>

*Note: Visit and day limits do not apply to severe mental illnesses and serious emotional disturbances of children.*

#### Chemical Dependency Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient detoxification</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient group therapy visits</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Outpatient individual therapy visits</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)</td>
<td>$100 per admission</td>
</tr>
</tbody>
</table>

#### Other Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>$50 per trip</td>
</tr>
<tr>
<td>Durable medical equipment in accord with our formulary</td>
<td>No charge</td>
</tr>
<tr>
<td>External prosthetic and orthotic devices</td>
<td>No charge</td>
</tr>
<tr>
<td>Health education for specific conditions: Individual visits</td>
<td>$10 per visit</td>
</tr>
<tr>
<td>Group visits</td>
<td>No charge</td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
</tr>
<tr>
<td>Hospice care</td>
<td>No charge</td>
</tr>
</tbody>
</table>

#### Emergency Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department visits</td>
<td>$50 per visit (waived if admitted directly to the hospital)</td>
</tr>
</tbody>
</table>

The above is only a summary of the benefits available under the Kaiser HMO. You may request a more detailed explanation of the benefits provided under the Kaiser HMO, including definitions of the terms used in the above summary, at no cost from the Fund Administrator.

### CATEGORY 1 AND 2 EMPLOYEES AND DEPENDENTS

#### HEALTH NET HMO PLAN

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Copayment Limit</strong></td>
<td></td>
</tr>
<tr>
<td>For each member</td>
<td>$1,500</td>
</tr>
<tr>
<td>For two-party</td>
<td>$3,000</td>
</tr>
<tr>
<td>For each family (3 or more members)</td>
<td>$4,500</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td>Administration of anesthetics</td>
<td>No charge</td>
</tr>
<tr>
<td>Allergy injection services (serum not included)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Allergy serum</td>
<td>Not covered</td>
</tr>
<tr>
<td>Allergy testing</td>
<td>No charge</td>
</tr>
<tr>
<td>All other injections</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Annual routine physical examinations</td>
<td>Not covered</td>
</tr>
<tr>
<td>Chemotherapy (professional services only)</td>
<td>No charge</td>
</tr>
<tr>
<td>Circumcision of newborn</td>
<td>No charge</td>
</tr>
<tr>
<td>Complications of pregnancy including medically necessary abortions</td>
<td>No charge</td>
</tr>
<tr>
<td>Dental services (when medically necessary to properly monitor, control, or treat a severe medical condition when excluded dental services are being performed)</td>
<td>No charge</td>
</tr>
<tr>
<td>Elective abortions</td>
<td>$150 Copayment</td>
</tr>
<tr>
<td>Genetic testing of fetus</td>
<td>No charge</td>
</tr>
<tr>
<td>Immunizations for foreign travel/occupational purposes</td>
<td>20% Copayment</td>
</tr>
<tr>
<td>Injections related to infertility services</td>
<td>50% Copayment</td>
</tr>
</tbody>
</table>
HEALTH NET HMO PLAN, continued

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Copayment/Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal delivery, Cesarean section (includes newborn inpatient care provided by a member physician)</td>
<td>No charge</td>
</tr>
<tr>
<td>Nuclear medicine (professional services only)</td>
<td>No charge</td>
</tr>
<tr>
<td>Other immunizations (except foreign travel/occupational - see above)</td>
<td>No charge</td>
</tr>
<tr>
<td>Periodic health evaluations (Includes routine, preventive care, and well-baby care)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Physician visit to hospital or skilled nursing facility (excluding care for mental disorders)</td>
<td>No charge</td>
</tr>
<tr>
<td>Physician visit to member’s home (at discretion of physician)</td>
<td>$20 Copayment</td>
</tr>
<tr>
<td>Postnatal office visit</td>
<td>No charge</td>
</tr>
<tr>
<td>Prenatal office visit</td>
<td>$10 Copayment/No charge 1</td>
</tr>
<tr>
<td>Rehabilitation therapy (inpatient/outpatient physical, speech, occupational and respiratory therapy; provided as long as significant improvement is expected)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Renal dialysis (professional services only)</td>
<td>No charge</td>
</tr>
<tr>
<td>Specialist consultations (Includes OB/GYN self-referral)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Surgeon/assistant surgeon in hospital or PPG</td>
<td>No charge</td>
</tr>
<tr>
<td>Vision and hearing examinations</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Visit to a physician, physician assistant or nurse practitioner at a Preferred Provider Group (PPG)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>X-ray and laboratory procedures</td>
<td>No charge</td>
</tr>
</tbody>
</table>

**Hospital Inpatient Care**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Copayment/Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlimited days of hospital care in a semi-private room or ICU with ancillary services (excluding care for mental disorders)</td>
<td>No charge</td>
</tr>
<tr>
<td>Maternity care (Includes routine nursery charges)</td>
<td>No charge</td>
</tr>
<tr>
<td>Organ and bone marrow transplants (non-experimental and noninvestigative Professional services only)</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>No charge</td>
</tr>
<tr>
<td>Skilled Nursing Facility (limited to 100 days a calendar year)</td>
<td>No charge</td>
</tr>
</tbody>
</table>

**Family Planning**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Copayment/Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptive devices</td>
<td>Not covered</td>
</tr>
<tr>
<td>Infertility services (including professional services, inpatient and outpatient care, treatment by injection and prescription drugs, if applicable)</td>
<td>50% Copayment</td>
</tr>
<tr>
<td>Reversal of sterilization</td>
<td>Not covered</td>
</tr>
<tr>
<td>Sterilization of females</td>
<td>Not covered</td>
</tr>
<tr>
<td>Sterilization of males</td>
<td>$150 Copayment</td>
</tr>
<tr>
<td>Sterilization of males</td>
<td>$50 Copayment</td>
</tr>
</tbody>
</table>

**Mental Health and Chemical Dependency Services**

Administered by Managed Health Network (MHN). Refer to the MHN telephone number on the back of your Health Net ID card.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Copayment/Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Services</td>
<td>No charge</td>
</tr>
<tr>
<td>Air ambulance</td>
<td>No charge</td>
</tr>
<tr>
<td>Blood, blood plasma, blood factors and blood derivatives</td>
<td>No charge</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
</tr>
<tr>
<td>Diabetic supplies (refer to the Introduction section for additional information)</td>
<td>No charge</td>
</tr>
<tr>
<td>Ground ambulance</td>
<td>No charge</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>Not covered</td>
</tr>
<tr>
<td>Home health visit (the copayment starts the 31st calendar day after the first visit)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Hospice care</td>
<td>No charge</td>
</tr>
<tr>
<td>Medical social services</td>
<td>No charge</td>
</tr>
<tr>
<td>Patient education</td>
<td>No charge</td>
</tr>
<tr>
<td>Prosthesis (replacing body parts)</td>
<td>No charge</td>
</tr>
</tbody>
</table>

**Emergency Care/Urgently Needed Care**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Copayment/Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of emergency room (facility and professional services)</td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>Use of urgent care center (facility and professional services)</td>
<td>$50 Copayment</td>
</tr>
</tbody>
</table>
SUMMARY OF BENEFITS

HEALTH NET HMO PLAN, continued

1 For each pregnancy, the initial prenatal visit requires a $10 copayment. No copayment is required for subsequent prenatal office visits.
2 Non-emergency care (including urgently needed care) received within the PPG service area must be performed or authorized by the member’s PPG in order for services to be covered. When urgently needed care is provided outside the PPG service area, authorization is not mandatory in order for services to be covered. When services are provided that meet the criteria for emergency care, whether within or outside the PPG service area, the services are covered, even if the member never contacted the PPG.
3 The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room or urgent care center.

The above is only a summary of the benefits available under the Health Net HMO. You may request a more detailed explanation of the benefits provided under the Health Net HMO, including definitions of the terms used in the above summary, at no cost from the Fund Administrator.

### CATEGORY 1 AND 2 EMPLOYEES AND DEPENDENTS

#### PACIFICARE HMO PLAN

<table>
<thead>
<tr>
<th>Services</th>
<th>You pay</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Copayment Maximum</strong></td>
<td>$2,000/individual</td>
</tr>
<tr>
<td>3 individual maximum per family</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td>Alcohol, Drug or Other Substance Abuse - Detoxification</td>
<td>No charge</td>
</tr>
<tr>
<td>Allergy Testing/Treatment (serum is not covered unless an allergy serum rider was purchased by your employer)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Cancer Clinical Trials 2,3</td>
<td>You pay balance, if any, after payment at contracting rate</td>
</tr>
<tr>
<td>Dental Treatment Anesthesia (additional charges for outpatient and inpatient surgery may apply)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Hearing Screening</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Hemodialysis (Physician office visit Copayment may apply)</td>
<td>$10 per treatment</td>
</tr>
<tr>
<td>Immunizations (for children under two years of age, refer to Well-Baby Care)</td>
<td>No charge</td>
</tr>
<tr>
<td>Infertility Services</td>
<td>50% Copayment.5</td>
</tr>
<tr>
<td>Laboratory and Radiology (when available through and authorized by the Member’s Participating Medical Group)</td>
<td>No charge</td>
</tr>
<tr>
<td>Maternity Care, Tests and Procedures</td>
<td>No charge</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Oral Surgery Services</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (including physical, occupational and speech therapy)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>No charge</td>
</tr>
<tr>
<td>Periodic Health Evaluations (Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group to determine your health status; for children under two years of age refer to Well-Baby Care.)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Physician Care (for children under two years of age, refer to Well-Baby Care)</td>
<td>No charge</td>
</tr>
<tr>
<td>Vision Refractions</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Vision Screening</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Well-Baby Care (Preventative health service, including immunizations recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group for children under two years of age. The applicable office visit Copayment applies to infants that are ill at time of services.)</td>
<td>No charge</td>
</tr>
</tbody>
</table>
**SUMMARY OF BENEFITS**

**PACIFICARE HMO PLAN, continued**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Woman Care (Includes Pap smear by your Primary Care Physician or an OB/GYN in your Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force.)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td><strong>Hospital Inpatient Care</strong></td>
<td></td>
</tr>
<tr>
<td>Alcohol, Drug or Other Substance Abuse - Detoxification</td>
<td>No charge</td>
</tr>
<tr>
<td>Bone Marrow Transplants (donor searches limited to $15,000 per procedure)</td>
<td>No charge</td>
</tr>
<tr>
<td>Cancer Clinical Trials</td>
<td>You pay balance, if any, after payment at contracting rate</td>
</tr>
<tr>
<td>Hospice Care (autologous (self-donated) blood up to $120.00 per unit)</td>
<td>No charge</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>No charge</td>
</tr>
<tr>
<td>Mastectomy/Breast Reconstruction (after mastectomy and complications from mastectomy)</td>
<td>No charge</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>No charge</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>No charge</td>
</tr>
<tr>
<td>Physician Care</td>
<td>No charge</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>No charge</td>
</tr>
<tr>
<td>Rehabilitation Care (including physical, occupational and speech therapy)</td>
<td>No charge</td>
</tr>
<tr>
<td>Skilled Nursing Care (up to one hundred (100) consecutive calendar days from the first treatment per disability)</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Retail Pharmacy (per Prescription Unit or up to 30 days)</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10</td>
</tr>
<tr>
<td>Brand Name</td>
<td>$25</td>
</tr>
<tr>
<td>Mail-Service Pharmacy (up to 3 Prescription Units or up to 90 days)</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$20</td>
</tr>
<tr>
<td>Brand Name</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td></td>
</tr>
<tr>
<td>Vasectomy</td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>Tubal ligation</td>
<td>$100 Copayment</td>
</tr>
<tr>
<td>Insertion/Removal of Intra-Uterine Device (IUD)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Intra-Uterine Device (IUD)</td>
<td>50% Copayment</td>
</tr>
<tr>
<td>Removal of Norplant</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Depo-Provera injection</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Depo-Provera medication (Limited to one Depo-Provera injection every 90 days)</td>
<td>$35 Copayment</td>
</tr>
<tr>
<td>Voluntary interruption of pregnancy (medical/medication and surgical)</td>
<td></td>
</tr>
<tr>
<td>--1st trimester</td>
<td>$75 Copayment</td>
</tr>
<tr>
<td>--2nd trimester (12-20 weeks)</td>
<td>$150 Copayment</td>
</tr>
<tr>
<td>--After 20 weeks</td>
<td>Not covered unless mother's life is in jeopardy or fetus not viable</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td></td>
</tr>
<tr>
<td>Mental Health Services (As required by state law, coverage includes treatment for Severe Mental Illnesses (SMI) of adults and children and for children the treatment of Serious Emotional Disturbance of Children (SED).)</td>
<td>$10 Copayment per visit</td>
</tr>
<tr>
<td>Inpatient, Residential and Day Treatment. Up to 30 days per Calendar Year based on the following levels of care:</td>
<td>No charge</td>
</tr>
<tr>
<td>Inpatient Treatment = 1 day</td>
<td></td>
</tr>
<tr>
<td>Residential Treatment = 70% of 1 day</td>
<td></td>
</tr>
<tr>
<td>Day Treatment = 60% of 1 day</td>
<td></td>
</tr>
<tr>
<td>Outpatient Treatment (Up to 30 visits per Calendar Year)</td>
<td>$10 Copayment</td>
</tr>
</tbody>
</table>
### SUMMARY OF BENEFITS

#### PACIFICARE HMO PLAN, continued

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency</strong></td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>**Urgently Needed Services (Medically Necessary services required outside the</td>
<td></td>
</tr>
<tr>
<td>geographic area served by your Participating Medical Group.)</td>
<td>waived if admitted as inpatient</td>
</tr>
<tr>
<td><strong>Severe Mental Illness Benefit</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient, Residential and Day Treatment (Unlimited days)</td>
<td>No charge</td>
</tr>
<tr>
<td>Outpatient Treatment (Unlimited visits)</td>
<td>$10 Copayment</td>
</tr>
<tr>
<td>Emergency</td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>waived if admitted as inpatient</td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>waived if admitted as inpatient</td>
<td></td>
</tr>
<tr>
<td><strong>Chemical Dependency Services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient and Outpatient Treatment (Maximum Annual Benefit for detoxification and</td>
<td>No charge</td>
</tr>
<tr>
<td>all levels of care limited to $25,000 per Calendar Year; $35,000 Lifetime Maximum</td>
<td></td>
</tr>
<tr>
<td>Benefit)</td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>waived if admitted as inpatient</td>
<td></td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>No charge</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$10 Copayment per visit</td>
</tr>
<tr>
<td>(30 visit annual maximum)</td>
<td>(30 visit annual maximum)</td>
</tr>
<tr>
<td>Cochlear Implants (Outpatient surgery or inpatient hospitalization and outpatient</td>
<td>No charge</td>
</tr>
<tr>
<td>rehabilitation therapy Copayments may apply)</td>
<td></td>
</tr>
<tr>
<td>Crisis Intervention (up to twenty (20) visits for Crisis Intervention per calendar</td>
<td>$35 Copayment</td>
</tr>
<tr>
<td>year)</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment, Corrective Appliances and Prosthetics</td>
<td>No charge</td>
</tr>
<tr>
<td>Health Education Services</td>
<td>No charge</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>No charge</td>
</tr>
<tr>
<td>Hospice Care (prognosis of life expectancy of one year or less)</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>Emergency Care/Urgently Needed Care</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency Services</td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>waived if admitted as inpatient</td>
<td></td>
</tr>
<tr>
<td>Urgently Needed Services (Medically Necessary services required outside the</td>
<td>$50 Copayment</td>
</tr>
<tr>
<td>geographic area served by your Participating Medical Group.)</td>
<td>waived if admitted as inpatient</td>
</tr>
</tbody>
</table>

---

1. Annual Copayment Maximum does not include Copayments for pharmacy and supplemental benefits.
2. Cancer Trial. Services require preauthorization by PacifiCare.
3. If you participate in a clinical trial provided by a Non-Participating Provider that does not agree to perform these services at the rate PacifiCare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Provider's billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayments, Coinsurance or Deductibles.
4. The newborn care Copayment does not apply when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the Combined Evidence of Coverage and Disclosure Form for more details.
5. Copayment applies regardless of whether this benefit is performed on an inpatient or outpatient basis. If performed on an inpatient basis, additional inpatient Copayment, if any, will apply.
6. Percentage Copayment amounts are based upon PacifiCare's contracted rate.
SUMMARY OF BENEFITS

PACIFICARE HMO PLAN, continued

7 Preauthorization is required for all Mental Health Services, Chemical Dependency Services and Severe Mental Illness (SMI) Benefits. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through PacifiCare Behavioral Health of California (PBHC), an affiliate of PacifiCare that specializes in mental health and chemical dependency benefits. PBHC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

8 Severe Mental Illness diagnoses include: Anorexia Nervosa, Bipolar Disorder, Bulimia Nervosa, Major Depressive Disorder, Obsessive-Compulsive Disorder, Panic Disorder, Pervasive Developmental Disorder or Autism, Schizoaffective Disorder, and Schizophrenia. In addition, the Severe Mental Illness Benefit includes coverage of Serious Emotional Disturbance of Children (SED).

9 The Lifetime Dollar Maximum for Severe Mental Illness will be applied to the Medical Plan Lifetime Dollar Maximum Benefit, if applicable.

Except in the case of a Medically Necessary Emergency or an UrgentlyNeeded Service (outside the geographic area served by your Participating Medical Group), each of the above-noted benefits is covered when authorized by your Participating Medical Group or PacifiCare. A utilization review committee may review the request for services.

The above is only a summary of the benefits available under the PacifiCare HMO. You may request a more detailed explanation of the benefits available under the PacifiCare HMO, including definitions of the terms used in the above summary, at no cost from the Fund Administrator.

DENTAL BENEFITS FOR CATEGORY 1 AND 2 EMPLOYEES AND DEPENDENTS

100% of usual, customary and reasonable Class I Diagnostic/Preventative Services (1) (2) (3) listed in the Dental Section.

80% of usual, customary and reasonable Class II Basic Services (1) through (10) listed in the Dental Section.

60% of usual, customary and reasonable Class III Major Services (1) through (7) listed in the Dental Section.

60% of usual, customary and reasonable Class IV Orthodontic Services.

Deductible Amount: $25 per person per year for Class III, and IV services.

Maximum Payment: $1,500 per calendar year for Class I, II and III services. $1,000 per lifetime for Class IV services.

VISION CARE BENEFITS

See Vision Care Benefits Section. – Page 61
LIFE INSURANCE
(STANDARD INSURANCE COMPANY)

For Employees Only

The Life Insurance benefits are available to employees only. Dependents are not eligible for Life Insurance benefits. Those making self-payments under COBRA are not eligible for this benefit. Life Insurance is provided through a contract with Standard Insurance Company.

SUMMARY OF LIFE INSURANCE BENEFIT

The Plan provides $15,000 of Group Term Life Insurance. (24 hour coverage)

REDUCTIONS IN INSURANCE

Your Life Insurance amount will be reduced based on your age, as shown below:

<table>
<thead>
<tr>
<th>Age</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 through 74</td>
<td>65%  $9,750</td>
</tr>
<tr>
<td>75 or over</td>
<td>50%  $7,500</td>
</tr>
</tbody>
</table>

LIFE INSURANCE EFFECTIVE DATE

Your Life Insurance becomes effective on the date you qualify for group health and welfare benefits.

WHEN LIFE INSURANCE ENDS

Your Life Insurance automatically ends on the earliest of:

1. The date the last period ends for which a required premium is made on your behalf to Standard Insurance Company by the I.B.E.W./NECA Sound and Communications Health & Welfare Plan;
2. The date the group policy terminates; or
3. The date you cease to be eligible for the Self-Funded Plan due to the lack of employer, or a combination of employer and employee contributions for the health and welfare benefits. A self-payment under COBRA to continue health and welfare benefits WILL NOT serve to extend your Life Insurance benefits.

WAIVER OF PREMIUM

Life Insurance will continue without premium payment while you are totally disabled if:

1. You become totally disabled while insured under the group policy prior to age sixty;
2. You remain totally disabled for at least one-hundred and eighty (180) days;
3. Satisfactory proof of total disability is furnished to Standard Insurance Company; and
4. Such proof is submitted to Standard Insurance Company no later than eighteen (18) months after you become totally disabled.

Totally Disabled means that, as a result of sickness, accidental injury, or pregnancy, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by training, education or experience.
LIFE INSURANCE

Premium payment must continue to be made during the first one-hundred and eighty (180) days of total disability. If you qualify for the Waiver of Premium Benefit, those premiums will be refunded to the Trust.

The amount of Life Insurance continued under the Waiver of Premium Benefit will be the amount of your Life Insurance in effect on the day preceding total disability. If you receive an Accelerated Benefit, the Life Insurance amount will be reduced according to the Accelerated Benefit provision.

All insurance under this Waiver of Premium Benefit will end on the earliest of:

1. The date that you are no longer totally disabled;
2. Ninety (90) days after the date Standard Insurance Company mails a request for additional proof of total disability, if satisfactory proof is not given;
3. The date you fail to attend an examination or cooperate with the examiner;
4. The effective date of an individual Life Insurance policy, if you have converted under Right to Convert; or
5. The date you attain age sixty-five (65).

ACCELERATED BENEFIT

1. Qualifying for an Accelerated Benefit.

If you qualify for a Waiver of Premium and you have a Qualifying Medical Condition, Standard Insurance Company will pay an accelerated benefit, after receiving satisfactory proof of loss. Qualifying Medical Condition means that you are terminally ill with a life expectancy of less than twelve (12) months.

Standard Insurance Company may have you examined at their expense in connection with your claim for an Accelerated Benefit. Any examination will be conducted by one or more physicians of their choice.

2. Application for Accelerated Benefit.

You must have at least $10,000 of Insurance in effect to be eligible (in other words, you must be age 70 or younger).

You must apply for an Accelerated Benefit. To apply you must give Standard Insurance Company satisfactory proof of loss on their forms. Proof of loss must include a statement from a physician that you have a Qualifying Medical Condition.

3. Amount of Accelerated Benefit.

You may receive an Accelerated Benefit of up to 75% of your insurance. The minimum Accelerated Benefit is $5,000.

If the amount of your insurance is scheduled to reduce within twenty-four (24) months following the date you apply for the Accelerated Benefit, your Accelerated Benefit will be based on the reduced amount.

The Accelerated Benefit will be paid to you once in your lifetime in a lump sum. If you recover from your Qualifying Medical Condition after receiving an Accelerated Benefit, Standard Insurance Company will not ask you for a refund.

4. Effect on Insurance and Other Benefits.

The amount of your Life Insurance after payment of the Accelerated Benefit will be:

- The amount of your Insurance as if no Accelerated Benefit had been paid; minus
- The amount of the Accelerated Benefit; minus
- An interest charge calculated as follows:
LIFE INSURANCE

(A) \( \times \) (B) \( \times \) (C) divided by 365 = interest charge.

(A) = The amount of the Accelerated Benefit.
(B) = The monthly average of Standard’s variable policy loan interest rate.
(C) = The number of days from payment of the Accelerated Benefit to the earlier of:
   (i) The date you die, and
   (ii) The date you have a right to convert.

5. Exclusions

No Accelerated Benefit will be paid if:

a. All or part of your insurance must be paid to your child(ren), or your spouse or former spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.

b. You are married and live in a community property state, unless you give Standard Insurance Company a signed written consent from your spouse.

c. You have filed for bankruptcy, unless you give Standard Insurance Company written approval from the Bankruptcy Court for payment of the Accelerated Benefit.

d. You are required by a government agency to use the Accelerated Benefit to apply for, receive, or continue a government benefit or entitlement.

e. You have previously received an Accelerated Benefit under the Group Policy.

f. You have made an assignment of all or part of your insurance unless you give us a signed written consent from the assignee.

g. You are required by a government agency to use the Accelerated Benefit to apply for, receive, or continue a government benefit or entitlement.

RIGHT TO CONVERT

1. Right to Convert

You may buy an individual policy of Life Insurance from Standard Insurance Company without submitting evidence of insurability if:

a. Your Life Insurance, whether under the group policy or continued under waiver of premium, ends or is reduced for any reason except payment of accelerated benefit; and

b. You apply in writing and pay Standard Insurance Company the first premium during the conversion period, which is the thirty-one (31) days after your Life Insurance ends.

Except as limited under 2. Limits On Right To Convert, the maximum amount you have a right to convert is the amount of your Insurance which ended.

2. Limits On Right To Convert

If your insurance ends or is reduced because of termination or amendment of the Group Policy, the following will apply:

a. You may not convert insurance which has been in effect for less than 5 years.

b. The maximum amount you have a right to convert is the amount of your insurance immediately prior to your termination of coverage under the group plan, minus any other group Life Insurance for which you become eligible during the thirty-one (31) days after.
3. **The Individual Policy**

You may select any form of individual Life Insurance policy Standard Insurance Company issues to persons of your age, except:

a. A term insurance policy;

b. A universal life policy;

c. A policy with disability, accidental death, or other additional benefits; or

d. A policy in an amount less than the minimum amount Standard Insurance Company issues for the form of Life Insurance you select.

The individual policy of Life Insurance will become effective on the day after the end of the conversion period. Standard Insurance Company will use their published rates for standard risks to determine the premium.

4. **Death During the Conversion Period**

If you die during the conversion period, Standard Insurance Company will pay a death benefit equal to the maximum amount you had a Right To Convert, whether or not you applied for an individual policy. The benefit will be paid according to the Benefit Payment and Beneficiary Provisions.

**CLAIMS**

1. **Filing a Claim**

Claims should be filed on Standard Insurance Company forms. You may obtain a claim form by contacting the Fund Administrator whose address and telephone number are listed in the Administration of the Plan section of this booklet.

2. **Time Limits on Filing Proof of Loss**

Proof of Loss must be provided within ninety (90) days after the date of the loss. If that is not possible, it must be provided as soon as reasonable possible, but not later than one (1) year after that ninety (90) day period.

Proof of Loss for Waiver of Premium must be provided within eighteen (18) months after the date of total disability. Further Proof of Loss will be required at reasonable intervals, but not more often than once a year after you have been continuously disabled for two years.

3. **Proof of Loss**

**Proof of loss** means written proof that a loss occurred:

a. For which the group policy provides benefits;

b. Which is not subject to any exclusions; and

c. Which meets all other conditions for benefits.

Proof of Loss includes any other information which may reasonably be required in support of a claim. Proof of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be provided until Standard Insurance Company receives Proof of Loss.

4. **Investigation of Claim**

Standard Insurance Company may have you examined at their expense at reasonable intervals. Any such examination will be conducted by specialists of their choice.
Standard Insurance Company may have an autopsy performed at their expense, except where prohibited by law.

5. **Time of Payment**

Standard Insurance Company will pay benefits within sixty (60) days after Proof of Loss is satisfied.

6. **Notice of Decision on Claim**

Your beneficiary will receive a written decision on a claim within a reasonable time after the claim is received.

If the beneficiary does not receive Standard Insurance Company's decision within ninety (90) days after they receive the claim, the beneficiary will have an immediate right to request a review as if the claim had been denied.

If the claim is denied, the beneficiary will receive a written notice of denial containing:

   a. The reasons for the decision;
   b. Reference to the parts of the group policy on which the decision is based;
   c. A description of any additional information needed to support the claim; and
   d. Information concerning the beneficiaries' right to a review of the decision.

7. **Review Procedure**

If all or part of a claim is denied, the beneficiary must request a review in writing within sixty (60) days after receiving notice of the denial.

The beneficiary may send Standard Insurance Company written comments or other items to support the claim, and may review any non-privileged information that relates to the request for review.

Standard Insurance Company will review the claim promptly after receiving the request. They will send notice of their decision within sixty (60) days after receiving the request, or within one-hundred and twenty (120) days if special circumstances require an extension. They will state the reasons for their decision and refer to the relevant parts of the group policy.

**BENEFIT PAYMENT AND BENEFICIARY PROVISIONS**

1. **Payment of Benefits**

Benefits payable because of your death will be paid to the beneficiary you name. Beneficiary means a person you name to receive death benefits.

2. **Naming a Beneficiary**

You may name one or more beneficiaries. Two or more surviving beneficiaries will share equally, unless you specify otherwise. You may name or change beneficiaries at any time without the consent of a beneficiary.

You must name or change beneficiaries in writing. Your beneficiary designation:

   a. Must be dated and signed by you;
   b. Must be delivered to the Fund Administrator, United Administrative Services, during your lifetime;
c. Must relate to the insurance provided under the group policy; and
d. Will take effect on the date it is delivered to the Fund Administrator.

You may obtain a beneficiary designation form by calling the Fund Administrator, United Administrative Services. The Fund Administrator’s address and telephone number are listed in the Administration of the Plan section of this benefit booklet.

3. Simultaneous Death Provision

If a beneficiary dies on the same day you die, or within 15 days thereafter, benefits will be paid as if that beneficiary had died before you, unless proof of loss with respect to your death is delivered to Standard Insurance Company before the date of the beneficiary’s death.

4. No Surviving Beneficiary

If you do not name a beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the classes below:

a. Your spouse;
b. Your child(ren);
c. Your parent(s);
d. Your brother(s) and sister(s); and
e. Your estate.

5. Methods of Payment

Benefits will be paid to the recipient (person who is entitled to benefits under this Benefit Payment and Beneficiary Provisions section) in a lump sum.

To the extent permitted by law, the amount payable to the recipient will not be subject to any legal process or to the claims of any creditor or creditor’s representative.

ALLOCATION OF AUTHORITY

Standard Insurance Company has full and exclusive authority to control and manage the group policy, to administer claims, and to interpret the group policy and resolve all questions arising in the administration, interpretation and application of the group policy.

Standard Insurance Company’s authority includes, but is not limited to:

1. The right to resolve all matters when review has been requested;

2. The right to establish and enforce rules and procedures for the administration of the group policy and any claim under it; and

3. The right to determine:

   a. Your eligibility for insurance;
   b. Your entitlement to benefits;
   c. The amount of benefits payable; and
   d. The sufficiency and the amount of information we may reasonably require to determine a, b, or c, above.
LIFE INSURANCE

Subject to the review procedures of the group policy, any decision Standard Insurance Company makes in the exercise of its authority is conclusive and binding.

TIME LIMITS ON LEGAL ACTIONS

No action at law or in equity may be brought until sixty (60) days after Standard Insurance Company has been given proof of loss. No such action may be brought more than three (3) years after the earlier of:

1. The date Standard Insurance Company receives proof of loss; and
2. The time within which proof of loss is required to be given.

ASSIGNMENT

The rights and benefits under the Group Policy cannot be assigned.

ADDRESS AND TELEPHONE NUMBER

The address and telephone number of Standard Insurance Company is:

Standard Insurance Company  
920 SW Sixth Avenue  
Suite #1002  
Portland, OR 97204  
Telephone: (503) 321-7000
For Employees Only

Accidental Death and Dismemberment insurance benefits are available to employees only. Dependents are not eligible for Accidental Death and Dismemberment insurance benefits. Those making self-payments under COBRA are not eligible for this benefit. Accidental Death and Dismemberment insurance is provided through a contract with Standard Insurance Company.

SUMMARY OF ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT

Accidental Death and Dismemberment insurance (AD&D) provides benefits for dismemberment or death resulting from accidental bodily injuries. The Accidental Death and Dismemberment insurance benefit is summarized below.

1. When Benefits are Payable

If you have an accident while insured for AD&D insurance, and the accident results in a loss, Standard Insurance Company will pay benefits according to the terms of the group policy after satisfactory proof of loss is received.

2. Definition of Loss for AD&D Insurance

Loss means loss of life, hand, foot or sight, which:

a. Is caused solely and directly by an accident;

b. Occurs independently of all other causes; and

c. Occurs within 365 days after the accident.

With respect to a hand or foot, loss means actual and permanent severance from the body at or above the wrist or ankle joint. With respect to sight, loss means entire and irrevocable loss of sight.

3. Amount Payable

The amount payable is equal to a percentage of your AD&D insurance in effect on the date of the accident. Your AD&D insurance is $15,000. The amount payable is as follows:

<table>
<thead>
<tr>
<th>LOSS</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>$15,000</td>
</tr>
<tr>
<td>One hand, one foot, or sight of one eye</td>
<td>$7,500</td>
</tr>
<tr>
<td>Two or more of the above losses</td>
<td>$15,000</td>
</tr>
</tbody>
</table>

No more than 100% of your AD&D insurance will be paid for all losses resulting from one accident.

4. Seat Belt Benefit

The amount of the seat belt benefit is $10,000.

Standard Insurance Company will pay a seat belt benefit if:

a. You die as the result of an automobile accident for which an AD&D insurance benefit is payable; and
b. You were wearing a seat belt at the time of the accident, as evidenced by a police accident report.
   
   (i) **Seat belt** means a properly installed seat belt, lap shoulder restraint, or other restraint approved by the National Highway Traffic Safety Administration.
   
   (ii) **Automobile** means a motor vehicle licensed for use on public highways.

5. **AD&D Insurance Exclusions**

No AD&D insurance benefit is payable if the Loss is caused or contributed to by any of the following:

a. War or act of war, declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

b. Suicide or other intentionally self-inflicted injury, while sane or insane.

c. Committing or attempting to commit assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at a scene of a violent disorder or riot while performing your official duties.

d. The voluntary use or consumption of any poison, chemical compound or drug, unless used or consumed according to the directions of a physician.

e. Sickness or pregnancy existing at the time of the accident.

f. Heart attack or stroke.

g. Medical or surgical treatment for any of the above.

6. **When AD&D Insurance Becomes Effective**

Your AD&D insurance becomes effective on the date you qualify for group health and welfare benefits.

7. **When AD&D Insurance Ends**

Your AD&D insurance automatically ends on the earliest of:

a. The date the last period ends for which a required premium is made on your behalf to Standard Insurance Company by the I.B.E.W./NECA Sound & Communications Health & Welfare Plan;

b. The date the group policy terminates;

c. The date you cease to be eligible for benefits by the Plan as a result of employer or a combination of employer and employee contributions for the health and welfare benefits. A self-payment under COBRA to continue health and welfare benefits will not serve to extend your AD&D insurance benefit.

d. The date you no longer qualify for group health and welfare benefits.

**CLAIMS**

1. **Filing a Claim for Benefits**

Claims should be filed on Standard Insurance Company claim forms. You may obtain a claim form by calling the Fund Administrator, United Administrative Services, whose address and telephone number are listed in the *Administration of the Plan* section of this Benefit Booklet.

2. **Time Limit for Filing Proof of Loss**

Proof of loss must be provided within ninety (90) days after the date of the loss. If that is not possible, it must be provided as soon as reasonably possible, but not later than one year after the ninety (90) day
period. If proof of loss is filed outside of these time limits, the claim will be denied. These limits will not apply while you or your beneficiary lacks legal capacity.

3. **Proof of Loss**

Proof of loss means written proof that a loss occurred:

a. For which the group policy provides benefits;
b. Which is not subject to any exclusions; and
c. Which meets all other conditions for benefits.

Proof of loss includes any other information Standard Insurance Company may reasonably require in support of a claim. Proof of loss must be written and must be provided at the expense of you or your beneficiary. No benefits will be provided until Standard Insurance Company receives proof of loss.

4. **Investigation of Claim**

Standard Insurance Company may have you examined at their expense at reasonable intervals. Any such examination will be conducted by specialists of their choice.

Standard Insurance Company may have an autopsy performed at their expense, except where prohibited by law.

5. **Time of Payment**

Standard Insurance Company will pay benefits within sixty (60) days after proof of loss is satisfied.

6. **Notice of Decision on Claim**

You or your beneficiary will receive a written decision on a claim within a reasonable period of time after Standard Insurance Company receives the claim.

If you or your beneficiary does not receive a decision within ninety (90) days after Standard Insurance Company receives the claim, you or your beneficiary will have an immediate right to request a review as if the claim had been denied.

If any part of the claim is denied, you or your beneficiary will receive a written notice of denial containing:

a. The reasons for the decision;
b. Reference to parts of the group policy on which the decision is based;
c. A description of any additional information needed to support the claim; and
d. Information concerning you or your beneficiaries’ right to review the decision.

7. **Review Procedure**

If all or a part of a claim is denied, you or your beneficiary may request a review in writing within sixty (60) days after receiving notice of the denial.

You or your beneficiary may send Standard Insurance Company written comments or other items to support the claim, and may review any non-privileged information that relates to the request for review.

Standard Insurance Company will review the claim promptly after they receive the request. Standard Insurance Company will send notice of their decision within sixty (60) days after they receive the request, or within one-hundred and twenty (120) days of special circumstances requiring an extension. Standard
Insurance Company will state the reasons for their decision and refer to the relevant parts of the group policy.

**BENEFIT PAYMENT AND BENEFICIARY PROVISIONS**

1. **Payment of Benefits**

   Benefits payable because of your death will be paid to your beneficiary. Beneficiary means the person you name to receive your benefits. Dismemberment benefits will be paid to you if you are living. Any dismemberment benefits which are unpaid at your death will be paid to your beneficiary.

2. **Naming a Beneficiary**

   You may name one or more beneficiaries. Two or more surviving beneficiaries will share equally, unless you specify otherwise. You may name or change beneficiaries at any time without the consent of a beneficiary.

   You must name or change beneficiaries in writing. Your beneficiary designation:

   a. Must be dated and signed by you;
   b. Must be delivered to the Fund Administrator, United Administrative Services, during your lifetime;
   c. Must relate to the insurance provided under the group policy; and
   d. Will take effect on the date it is delivered to the Fund Administrator. You may obtain a beneficiary designation form by calling the Fund Administrator, United Administrative Services. The Fund Administrator’s address and telephone number are listed in the *Administration of the Plan* section of this booklet.

3. **Simultaneous Death Provision**

   If a beneficiary dies on the same day you die, or within fifteen (15) days thereafter, benefits will be paid as if that beneficiary had died before you, unless proof of loss with respect to your death is delivered to us before the date of the beneficiary's death.

4. **No Surviving Beneficiary**

   If you do not name a beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the classes below:

   a. Your spouse;
   b. Your child(ren);
   c. Your parent(s);
   d. Your brother(s) and sister(s); and
   e. Your estate.

5. **Methods of Payment**

   Benefits will be paid to the recipient (person who is entitled to benefits under this Benefit Payment and Beneficiary Provisions section) in a lump sum.

   To the extent permitted by law, the amount payable to the recipient will not be subject to any legal process or to the claims of any creditor or creditor’s representative.
ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Allocation of Authority

Standard Insurance Company has full and exclusive authority to control and manage the group policy to administer claims, and to interpret the group policy and resolve all questions arising in the administration, interpretation and application of the group policy.

Standard Insurance Company’s authority includes, but is not limited to:

1. The right to resolve all matters when a review has been requested;

2. The right to establish and enforce rules and procedures for the administration of the group policy and any claim under it; and

3. The right to determine:
   a. Your eligibility for insurance;
   b. Your entitlement to benefits;
   c. The amount of benefits payable; and
   d. The sufficiency and the amount of information we may reasonably require to determine, a, b, or c, above.

Subject to the review procedures of the group policy, any decision Standard Insurance Company makes in the exercise of its authority is conclusive and binding.

Time Limits on Legal Actions

No action at law or in equity may be brought until sixty (60) days after Standard Insurance Company has been given proof of loss. No such action may be brought more than three (3) years after the earlier of:

1. The date Standard Insurance Company receives proof of loss; and

2. The time within which proof of loss is required to be given.

Assignment

The rights and benefits under the group policy cannot be assigned.

Address and Telephone Number

The address and telephone number of Standard Insurance Company is:

Standard Insurance Company
920 SW Sixth Avenue
Suite #1002
Portland, OR 97204
Telephone: (503) 321-7000
SHORT-TERM DISABILITY BENEFIT

For Employees Only

Accident and Sickness (Weekly Benefit)

1st thirteen weeks ........................................................................................................................................... $100
2nd thirteen weeks ........................................................................................................................................... $150

Benefits begin on the first day for an accident or hospital confinement and on the eighth day in case of a non-hospital illness. The benefit covers non-occupational accidents or illness only.

This protection is designed to partially replace an Employee’s income during periods of temporary disability. The Plan provides for payment up to the maximum shown in the Summary of Benefits beginning on the 1st day of such disease or illness if hospital-confined. The compensation continues for a maximum period of 26 weeks for each disability. This benefit is limited to a lifetime maximum of four (4) separate claim occurrences.

The Employee need not be confined to his/her home, but he/she must be wholly and continuously disabled as to be prevented from performing each and every function pertaining to his/her employment and must be under the care of a legally qualified physician or surgeon. Proof that a person continues to be disabled will be required at reasonable intervals by the Trust. If a person fails to furnish proof or refuses to be examined by a physician (designated and paid by the Trust), such person will no longer be considered disabled.

All disability absences will be considered as having occurred during a single period of disability unless acceptable evidence is furnished that:

(a) the causes of the latest disability absence cannot be connected with the cause of any of the prior disability absences and the latest disability absence occurs after return to active full-time work for at least one day; or

(b) a connection with prior disability absences can be established but that, between the last of the previous disability absences which are connected and the latest one, you have returned to active full-time work for at least two (2) consecutive weeks.

If a period of disability is extended by a new cause while short term disability benefits are payable, short term disability benefits will continue while you remain disabled. However, ‘1’ and ‘2’ below will apply.

1. Short term disability benefits will not continue beyond the end of the original Maximum Benefit Period.

2. The General Exclusions and Limitations section will apply to the new cause of Disability, as well as the original cause of Disability.

GENERAL EXCLUSIONS

Certain disabilities are beyond the scope of this short term disability benefit. Therefore, a person will not receive benefits for a disability arising from any of the following causes:

1. Intentionally self-inflicted injury while sane or insane;

2. The commission of, or participation in a felony;

3. An act of war (whether declared or not), insurrection, rebellion or participation in a riot or civil commotion;

4. Arising out of or in the course of any employment for wage or profit; and

5. Where such bodily injury or disease is due to such person’s willful engagement in any illegal activity or occupation or the self-infliction of such, or any other injury resulting from chronic alcoholism or the use of narcotics, unless the same were administered pursuant to the orders of a licensed physician.

LIMITATIONS
1. **Care of a Physician**

You must be under the ongoing care of a legally qualified Physician during the Benefit Waiting Period and thereafter. No short term disability benefits will be paid for any period of disability when you are not under the ongoing care of a qualified physician or surgeon.

2. **Occupational Benefits**

No short term disability benefits will be paid for any period you are found eligible to receive benefits under a workers’ compensation law or similar law. If your claim for worker’s compensation benefits is accepted, compromised or settled (whether disputed or undisputed), you must repay the Plan for the full amount of any payments to you while your claim for occupational benefits was pending.

3. **Paid Sick Leave**

No short term disability benefits will be paid for any period when you are receiving paid sick leave from your Employer.

4. **Working**

No short term disability benefits will be paid for any period: (a) when you are working for wage or profit for any employer, or (b) when you are self-employed.

**BENEFIT TERMINATION**

Your benefit ends automatically on the earliest of ‘1’ through ‘4’ below:

1. The date you are no longer Disabled.

2. The date your Maximum Benefit Period ends.

3. The date you die.

4. The date you begin working for any employer.

The disability absence must commence while Plan coverage is in force and while the Employee was working or signed on the out-of-work list and available for work for a contributing employer.

A terminated Employee, who is not signed on the out-of-work list or is making COBRA self-payments is not eligible for this benefit. Dependents are not eligible for this benefit.

Weekly payments for this short-term disability plan are paid directly from Trust Fund assets.

Claims received at the Fund Administrator's Office more than sixty (60) days after the inception of the Employee's disability absence will not be paid, unless the Employee provides satisfactory evidence that he/she has remained continuously disabled from the inception of the disability absence through the date the application is received.

Your short-term disability benefit payments are subject to Federal income tax and, if applicable, state income tax. The Fund Administrator will mail W-2 forms for short-term disability benefit payments made during the calendar year to Employees by January 31st of the following year.
SELF-FUNDED MEDICAL BENEFITS

FOR CATEGORY 1 AND 2 EMPLOYEES AND DEPENDENTS

HOSPITAL AND MEDICAL

Deductible .......................................................................................................................... a cash deductible of $50

(Out-of-pocket expense - Family Maximum $150)

A maximum of three times the individual cash deductible, no more than $50 of which may be satisfied by only one person, will be applied to the covered charges incurred by a family unit during any benefit period.

If two or more eligible members of your family are injured in the same accident, only one deductible has to be met during the calendar year in which the accident occurs and the following calendar year for covered charges incurred as a result of the accident. Separate deductibles will still apply to charges not related to the common accident.

PPO Contracted Hospitals

If you use a Blue Cross Preferred Provider Organization (PPO) Contract Hospital, your deductible is waived and the Plan will pay ninety percent (90%) (instead of eighty percent (80%)) of covered charges of the first $2,500 ($7,500 per family unit) of eligible expenses and will pay one hundred percent (100%) (instead of eighty percent (80%)) of covered charges for the remainder of the calendar year. A list of Contract Hospitals is provided to you automatically, free of charge, as a separate document. The ten percent (10%) coinsurance of covered charges will apply to the out-of-pocket expense maximum of $500 for the individual and $1,500 per family.

The $2,500 stop-loss threshold does not apply to services rendered by a non-PPO hospital provider. Therefore, the Plan will pay 80% of all Usual, Customary and Reasonable Charges each calendar year in excess of the $50 deductible for services rendered by a non-PPO hospital provider even for expenses that exceed $2,500.

Benefit Percentage .......................................................................................................................... 80%

The self-funded medical plan pays eighty percent (80%) of covered charges incurred by covered individuals during a calendar year in excess of the $50 individual deductible amount ($150 maximum per family unit). The twenty percent (20%) coinsurance of covered charges will apply to the out-of-pocket expense maximum of $500 for the individual and $1,500 per family.

Maximum Lifetime Benefit

The maximum lifetime benefit per individual is One Million Dollars ($1,000,000).

Benefit Period

A Benefit Period for an individual begins when the individual has incurred in a calendar year covered charges which exceed the deductible amount. Included will be covered charges incurred in October, November and December of the preceding calendar year for which no benefits were paid because such charges were applicable to the deductible amount.

A Benefit Period for an individual ends on the earliest of the following:

1. The last day of the calendar year in which it was established; or
2. The day coverage provided under this Plan ends; or
3. The day the maximum benefit is paid.
To receive maximum benefits for hospital and mental health services, you must obtain pre-certification from Blue Cross by calling 1-800-274-7767.

The Blue Cross PPO is a hospital and physician preferred provider organization. A list of providers is furnished to you automatically, free of charge, as a separate document.

1. You are free to use any hospital or doctor when services are necessary. However, when you or your covered dependents receive services from a participating provider, the charges are less and your out-of-pocket co-payment is lower.

2. Participating hospitals and physicians' offices agree to bill the health plan and not require payment by the patient at the time of service. Any billing for the patient's portion (if any) is after the Plan has paid and sent its Explanation of Benefits to the patient and to the hospital or physician.

3. For emergencies requiring immediate care, use the most readily available qualified help.

4. Non-emergency hospital admissions should have pre-admission authorization whether the planned admission is at a participating or a non-participating hospital. Please be sure that your physician's office remembers to telephone the review office at 1-800-274-7767. For emergency admissions, the review office should be notified within 24 hours.

Pre-Certification relates only to the reasonableness of the services approved and does not guarantee that you actually have coverage for an admission date. Eligibility for benefits (coverage) is different than pre-qualification.

The Process Is Simple

There are three simple steps to the medical inpatient program: Pre-Admission Review, Concurrent Review, and Discharge Planning.

Pre-Admission Review

If your doctor determines that you or a covered member of your family requires hospitalization, remind the doctor to contact the Blue Cross PPO prior to your admission. To allow sufficient time for processing, ask your doctor to contact us as soon as your hospitalization is planned. During this call, Blue Cross gathers the necessary medical information to fully review the case and assign an appropriate hospital length of stay. This call must be made for all non-emergency admissions.

Some of the issues addressed during Pre-Admission Review are:

• Nervous or mental disorders.

• What is the medical necessity for the admission?

• Are outpatient services more appropriate?

• Is a second surgical opinion required?

• What is the appropriate length of stay for this condition?

Emergency Admissions
Self-Funded Medical Benefits

Emergency admissions do not require a Pre-Admission Review. However, Blue Cross must be notified of an emergency hospitalization the first business day following admission. This call may be made by the patient, a family member, the physician, or the hospital staff.

Be certain everyone in your family knows that all hospital admissions under the self-funded MEDICAL plan need to be called into Blue Cross. The physician and the hospital will be happy to help you if they know you are covered by a review service.

Concurrent Review

Once you have been admitted to the hospital, the Concurrent Review begins. This step occurs automatically. The objective is to monitor the hospitalization and avoid unnecessary days in the hospital.

If your condition requires extending your hospitalization beyond those days originally authorized, the need for additional days will be reviewed. Blue Cross will contact your doctor to coordinate this review.

Discharge Planning

During your hospital stay, Blue Cross continues to look for ways to shorten your hospital stay. In some cases, continued care in the comfort of your own home or as an outpatient will be more appropriate than staying in a hospital. Home health care and outpatient services offer many patients all the care they need and are much less expensive than a hospital.

Discharge planning seeks to offer the best possible care in the most cost-effective setting.

Appeals Process

If you or your doctor disagree with a utilization review decision, Blue Cross provides an appeal process. If that situation arises, you or your doctor can request that Blue Cross's decision be reviewed.

Utilization Review

It works for you - with your help!

- This program helps assure that the care you receive is necessary and appropriate.
- This program helps assure that you return home as soon as possible.
- This program helps you and your plan save money.

Blue Cross PPO

Health Care Information and Assistance

The health care information and assistance service can help if you have questions or concerns about your health or health care. This program is your advocate to assist you in making informed health decisions, and to assist you if you need help in dealing with the health care system.
SELF-FUNDED MEDICAL BENEFITS

How It Works

Information and assistance can be obtained by calling toll-free:

Blue Cross PPO
1-800-274-7767
Monday through Friday
8:00 A.M.-5:00 P.M.

The assistance and information line is staffed by nurses and health care professionals.

All calls are handled confidentially.

The health care information service can provide assistance through factual information. The program does not give medical opinion or specific medical advice.

Examples of Questions or Assistance

- Questions about type of health care available for specific problems, and treatment options within the health care system.
- How to obtain a second opinion.
- What questions should I ask my doctor?
- Information about medications used or prescribed.
- Questions about the cost of care.
- How to benefit from cost-containment features of your health plan.
- Information to assist in understanding proposed treatments or surgery.

COVERED CHARGES

1. Semi-private room and board and routine nursing for confinement in a hospital.

2. Semi-private room and board and routine nursing for confinement in a skilled nursing facility (not to exceed the average semi-private room rate). Services must commence within 14 days after discharge from a stay of three (3) or more days in an acute care hospital.

3. Intensive Nursing Care for each day of confinement in a hospital as follows:
   a. For those hospitals which make a separate charge for Intensive Nursing Care, the hospital's specific charge for Intensive Nursing Care is covered;
   b. For those hospitals which make a combined charge for Room and Board and Intensive Nursing Care, that part of the combined charge that is in excess of the hospital's prevailing semi-private Room and Board rate will be the covered charge for Intensive Nursing Care.

4. Anesthetics and their administration.

5. Medical treatment given by or at the direction of a physician, if such treatment is within the scope of the provider.

6. Usual, Customary and Reasonable Charges of a physician or surgeon for the performance of an operation, the repair of a dislocation or fracture, and for medical services. Charges of an assistant surgeon are also covered.
7. Services of a Licensed Registered Nurse (R.N.) for private duty nursing services in a hospital.

1) Services of a Licensed Practical Nurse (L.P.N.) for private duty nursing services in a hospital.

9. Services of a licensed physiotherapist.

10. Charges by a doctor or speech therapist for rehabilitative speech therapy due to an illness (other than a functional nervous disorder), or due to surgery on account of an illness. If the speech therapy is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

11. X-ray exams (other than dental), lab tests, and other diagnostic services.

12. X-ray and radiation therapy.

13. Charges for the repair of sound natural teeth (including their replacement) required as a result of, and within six (6) months of an accidental bodily injury that occurs while the person is covered under the Plan.

14. Transportation that is medically necessary and recommended by your attending physician within the United States and Canada of the covered individual by professional ambulance service, railroad, or scheduled airline to, but not returning from a hospital or sanitarium. These charges will be covered only if the covered individual's illness cannot be adequately treated in the locale where the illness occurs.

15. Medical supplies as follows:
   a. Drugs which require a written prescription from a doctor and must be dispensed by a licensed pharmacist or doctor;
   b. Blood and other fluids to be injected into the circulatory system;
   c. Artificial limbs and eyes for loss of natural limbs and eyes which occurred while coverage is in force;
   d. Lens, each eye (contact or frames) immediately following and because of cataract surgery only;
   e. Casts, splints, trusses, braces, crutches, and surgical dressings;
   f. Purchase or rental of hospital-type equipment for kidney dialysis for your personal and exclusive use. The total purchase price considered will be on a monthly pro-rata basis during the first twenty-four (24) months of ownership, but only so long as a dialysis treatment continues to be medically necessary. Also covered are all charges for supplies, materials and repairs necessary for the proper operation of such equipment and reasonable and necessary expenses for the training of a person to operate and maintain the equipment for your sole benefit. No benefits are paid on or after the day you are entitled to benefits under Medicare.
   g. Rental (not to exceed the purchase price) or purchase (if the cost is less than the rental for the period required) of durable medical equipment such as oxygen, a wheelchair, or hospital bed for medically necessary therapeutic treatment of a covered illness or non-industrial injury, which is:
      (1) manufactured specifically for medical use, and of no further use when medical need ends;
      (2) usable only by the patient;
      (3) not primarily for the comfort or hygiene of the eligible individual, or solely to aid the caregiver;
      (4) not for environmental control;
      (5) not for exercise;
      (6) approved as effective and usual and customary treatment of a condition as determined by the Plan; and
h. Medically necessary prosthesis.

16. Maternity Expenses and Well Baby Coverage (Employee and spouses Only):

Maternity expenses are covered the same as any other illness and cover only female Employees and dependent wives. Coverage must be in effect at the time of delivery. Hospital well baby nursery charges are covered only in BlueCross PPO contract hospitals and only during the mother’s normal maternity stay.

Effective January 1, 1998, group health plans and health insurance issuers offering group health coverage generally may not, under federal law, restrict available benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of time in excess of 48 hours (or 96 hours).

17. Breast reconstruction following a mastectomy. In accordance with the Women’s Health and Cancer Rights Act of 1998 (WHCRA), if you receive mastectomy-related benefits, coverage will be provided for the following mastectomy-related services as determined in consultation between you and your attending physician:

a. All stages of reconstruction of the breast on which the mastectomy has been performed.

b. Surgery on, and reconstruction of, the other breast to produce a symmetrical appearance.

c. Prostheses.

d. Treatment of physical complications, including lymphedemas, at all stages of mastectomy.

Any exclusion of benefits for cosmetic services does not apply to this benefit. This benefit is subject to the annual deductible and copayments specified above.

18. Fees for chiropractic and acupuncture treatment are limited to $25 per call with a maximum of twenty calls per calendar year. Payments are subject to the Plan’s deductible and co-insurance. Maximum X-ray charges for chiropractic services are limited to $100 per calendar year.

**PRESCRIPTION DRUG PROGRAM**

(For Self-Funded Medical Plan Participants Only)

The following are your two (2) options for getting your drug prescriptions filled:

Retail Pharmacy

**ACUTE – (NON-MAINTENANCE) THERAPIES**

To obtain prescription drugs for acute or short-term medication needs directly from a retail pharmacy, you may pay for the prescription at the time of purchase. Obtain a pharmacy receipt that lists the drugs name, quantity dispensed and date of service. Contact the Fund Administrator for a reimbursement claim form. Mail the pharmacy receipt together with your name, address, social security number and the claim form to:

United Administrative Services
1120 S. Bascom Avenue
San Jose, CA 95128-3590

Telephone: (408) 288-4400
Toll-Free: (800) 541-8059
SUMMARY OF BENEFITS – (NON-MAINTENANCE DRUGS)

Reimbursement for non-maintenance drugs will be at 80% of the prescription cost with a $50 annual deductible. After the annual deductible is met you pay only the 20% copayment for each eligible prescription.

For Example:

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG YOU ARE CHARGED</th>
<th>COVERED CHARGES</th>
<th>ANNUAL DEDUCTIBLE (YOU PAY)</th>
<th>PLAN PAYS 80% REIMBURSED TO YOU AFTER YOU MAIL IN RECEIPT</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>$65</td>
<td>$65</td>
<td>$50</td>
<td>$65 x 80% = $52</td>
<td>$13</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$(after meeting $50 annual deductible)</td>
</tr>
</tbody>
</table>

The only prescriptions which are reimbursed at 80% are for non-maintenance drugs which require a written prescription from a doctor, which must be dispensed by a licensed pharmacist or doctor, do not exceed a ninety (90) day supply and are not subject to any limitations and exclusions in this Benefit Booklet.

MAINTENANCE THERAPIES

To obtain prescription drugs for long-term maintenance medication needs directly from a retail pharmacy, you may pay for the prescription at the time of purchase. Be sure to obtain a pharmacy receipt that lists the drug name, quantity dispensed and date of service. Contact the Fund Administrator for a reimbursement claim form. Mail the pharmacy receipt together with your name, address, social security number and the claim form to:

United Administrative Services
1120 S. Bascom Avenue
San Jose, CA  95128-3590

Telephone:  (408) 288-4400
Toll-Free:     (800) 541-8059

SUMMARY OF BENEFITS – (MAINTENANCE DRUGS)

Reimbursement for maintenance drugs will be 50% of the prescription with a $50 annual deductible. After the annual deductible is met you pay only the 50% copayment for each eligible prescription.

For example:

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG YOU ARE CHARGED</th>
<th>COVERED CHARGES</th>
<th>ANNUAL DEDUCTIBLE (YOU PAY)</th>
<th>PLAN PAYS 80% REIMBURSED TO YOU AFTER YOU MAIL IN RECEIPT</th>
<th>YOU PAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>$65</td>
<td>$65</td>
<td>$50</td>
<td>$65 x 50% = $32.50</td>
<td>$32.50</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$(after meeting $50 annual deductible)</td>
</tr>
</tbody>
</table>

The only prescriptions which are reimbursed at 50% are for drugs which require a written prescription from a doctor, which must be dispensed by a licensed pharmacist or doctor, do not exceed a ninety (90) day supply and are not subject to any limitations and exclusions in this Benefit Booklet.
Mail Order Pharmacy

MAIL SERVICE PHARMACY
(MEDCO)

FOR MEDICATIONS YOU TAKE ON A LONG-TERM, ONGOING BASIS

If you’re taking medication on an ongoing basis, such as medication to reduce blood pressure or treat asthma, diabetes, or any chronic health condition, you should be using the mail service pharmacy.

WITH MAIL SERVICE...

• You can be assured that Medco Rx Services follow strict quality and safety controls for every prescription filled.
• Pharmacies are staffed with highly trained, registered pharmacists.
• You can phone in your refill orders from home, toll-free: 1-800-473-3455.
• A registered pharmacist is available for emergency consultations 24 hours a day, seven days a week by contacting Member Services.
• And to make the process simpler and quicker, there’s EasyRx. EasyRX is the name for how you may order new and refill prescriptions from the mail service pharmacy. Just follow the EasyRX steps listed in this section.

SUMMARY OF BENEFITS – MAIL SERVICE PRESCRIPTION DRUG PROGRAM

<table>
<thead>
<tr>
<th>COPAYMENT FOR GENERIC DRUGS</th>
<th>COPAYMENT FOR BRAND NAME DRUGS</th>
<th>PRESCRIPTION DRUG SUPPLY MAXIMUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5</td>
<td>$10</td>
<td>90 day maximum supply</td>
</tr>
</tbody>
</table>

Covered Prescriptions: The Plan covers maintenance drugs which require a written prescription from a doctor and which must be dispensed by a licensed pharmacist or doctor are covered, subject to any limitations and exclusions in the Benefit Booklet.

EasyRx

THE SIMPLE WAY TO USE YOUR MAIL SERVICE PHARMACY

EasyRx makes it easy to order your medications from Medco Rx Services.

1. Ordering new prescriptions

Ask your doctor to prescribe the needed medication for up to ninety (90) days, if appropriate. Mail your prescription and correct copayment in the special order envelope. Initial special order envelopes to start the prescription drug program may be obtained from the Fund Administrator.
2. Refilling your medication

To be sure you never run short of your prescription medication, you should reorder on or after the refill date indicated on the refill slip or on your medication container, or when you have 14 days of medication left.

To order online: Logon to the website: www.medco.com Be sure to have on hand the following: Your member ID number and the prescription number (it’s the 12-digit number on your refill slip).

To order by phone: Call 1 (800) 4REFILL (1-800-473-3455) and use the automated refill system. Have your member ID number and refill slip with the prescription information ready.

To order by mail: Simply mail your refill slip and copayment in the special order envelope.

3. Delivering your medication

Your order will be processed promptly – usually within 48 hours of receipt – and your medication will be sent to you via U.S. mail or UPS along with instructions for future refills, if applicable. After processing, please allow approximately one week for normal mail delivery. A leaflet explaining the purpose of the drug, correct dosages and other helpful information may also be included.

4. Paying for your medication

You may pay by check or money order or you may authorize billing to your credit card: VISA, MasterCard, Discover/NOVUS, American Express or Diners Club.

For your convenience, Medco can maintain a credit card on file and charge all future orders to this card. To do this, simply call the Automated Enrollment application at 1 (800) 948-8779 and they will ask you to enter your credit card and expiration date so that future orders are charged to this card.

Note: Certain controlled substances and several other prescribed medications may be subject to other dispensing limitations (e.g. quantities dispensed) and the professional judgment of the pharmacist. Federal law prohibits the return of dispensed controlled substances.

Generic Drugs

The brand name is the product name under which a drug is advertised and sold. Generic medications contain the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their brand name counterparts. Generally, generic drugs cost less than a brand name drug.

Please ask your doctor to prescribe generic drugs whenever appropriate.

Drug Utilization Review

Safe and Appropriate Use of Medications

Under this program, you and your covered dependents benefit from a medication safety review. Prescriptions filled through Medco’s pharmacies are reviewed for potential drug interactions based on your personal medication profile. This is especially important if you take many different medications or see more than one doctor. If there is ever a question about your mail service prescription, your pharmacist will contact your physician before dispensing the medication.

Education and Safety

In addition to giving you important information such as drug interactions and possible side effects with every prescription mailed, Medco will also offer, through the Internet, the tools you need to help manage and improve your health. Reach them at: www.medco.com.
SUPPLEMENTAL ACCIDENT BENEFIT  
(For Self-Funded Medical Plan Participants Only)

Should you or an injured member of your family need medical attention as a result of accidental bodily injuries within ninety (90) days from an accident, the Plan will pay for Usual, Customary and Reasonable Charges up to the Maximum Benefit shown in the Summary of Benefits for the following:

1. Surgery or medical attention performed by a legally qualified doctor of medicine;
2. Hospital care;
3. Nursing care provided by a registered graduate nurse.

Any expense for which benefits are payable under this provision will not be payable under the Comprehensive Medical Benefits provision of this Plan.

ANNUAL HEALTH SCREEN  
(For Self-Funded Medical Plan Participants Only)

Self-Funded participants and their spouses are entitled to 100% coverage for annual health screens.

The annual health screen is provided to detect common disease processes in the early, most treatable stage and to emphasize the importance of maintaining a healthy lifestyle through education in personal risk reduction. Annual health screens include: chemistry panels, occult blood tests, PSA (Prostate-Specific Antigen), breast examinations, mammographies, and pap smear examinations.

REPLACEMENT OF ORGANS OR TISSUE

1. The following procedures are payable on the same basis as any other illness:
   a. Cornea transplants;
   b. Artery or vein transplants;
   c. Kidney transplants;
   d. Joint replacements;
   e. Heart valve replacements;
   f. Implantable prosthetic lenses in connection with cataracts;
   g. Prosthetic bypass or replacement vessels;
   h. Bone marrow transplants;
   i. Cord blood transplants.

2. The following procedures are payable on the same basis as an illness up to a maximum lifetime benefit per individual of $200,000. This maximum applies for each type of procedure and to all charges incurred as a result of the transplant(s):
   a. Heart transplants;
   b. Heart and lung transplants;
   c. Liver transplants.
If you or your Dependent incur expenses for transplant surgery as a recipient, the following are included as covered services:

1. The use of temporary mechanical equipment, pending the acquisition of "matched" human organ(s);
2. Multiple transplant(s) during one operative session;
3. Replacement(s) or subsequent transplant(s);
4. Follow-up expenses for covered services (including immunosuppressant therapy) up to $10,000;

The Plan will pay the expense incurred by a donor(s) up to $10,000 for the following:

1. Testing to identify suitable donor(s);
2. The expense for the acquisition of organ(s) from a donor;
3. The expense of life support of a donor pending the removal of a usable organ(s);
4. Transportation for a living donor;
5. Transportation of organ(s) or a donor on life support.

Exceptions

The Plan will not pay for:

1. Any expenses when approved alternative remedies are available;
2. Any animal organ or mechanical (a) equipment, (b) device, or (c) organ(s), except as provided under this provision;
3. Any financial consideration to the donor other than for a covered expense which is incurred in the performance of or in relation to transplant surgery; and
4. Anything excluded under the General Exclusions and Limitations section of the Benefit Booklet.

Definitions

Transplant Surgery means transfer of a body organ(s) from the donor to the recipient.

Donor means a person who undergoes a surgical operation for the purpose of donating a body organ(s) for transplant surgery.

Body Organ means any of the following: (a) kidney, (b) heart, (c) heart/lung, (d) liver, (e) pancreas (when condition not treatable by use of insulin therapy), (f) bone marrow (for leukemia), and (g) cornea.

Recipient means a covered person who undergoes a surgical operation to receive a body organ transplant.
LAB BENEFITS
(For Self-Funded Medical Plan Participants Only)

You have the following two options for outpatient laboratory testing services:

1. **LabOne**

   Participants in the Self-Funded Medical Plan may use the LabOne Lab Card Program to receive outpatient laboratory testing services with no out-of-pocket costs.

   The next time you visit your doctor, tell them that you are a member of the LabOne Program, and be sure to show your doctor your Lab Card.

   Your specimens can be drawn in your doctor’s office, and the doctor may charge a reasonable fee for collecting the specimen. However, specimens must be sent to LabOne in order for you to receive this no-cost benefit. If you choose to have your doctor send your specimens to a laboratory other than LabOne, a claim will be filed and your regular benefits will apply.

   If your doctor is unable to draw specimens in his/her office, simply visit one of LabOne's conveniently located, approved service centers. There is no charge for specimen collection at a LabOne service center.

   You pay nothing for outpatient laboratory tests when you use your Lab Card. You also pay nothing for the collection of the specimen if you use a LabOne service center. If you have any questions regarding the Lab Card benefit, please contact LabOne at 1-800-646-7788.

2. **GROUP HEALTH SYSTEMS**

   The Plan has also engaged Group Health Systems (GHS) to provide a network of clinical laboratories at special discount rates. If you use a participating GHS laboratory, you will receive outpatient laboratory testing services with no out-of-pocket costs. If you do not use a participating GHS laboratory (or a LabOne laboratory), the Plan will pay only 80% of the billed amount. A list of GHS facilities may be obtained from the Fund Administrator.

   When your doctor orders laboratory testing services, inform him or her that you are a member of the GHS laboratory program. If your doctor does not draw specimens in the office, visit the nearest participating GHS laboratory and present your Plan membership card for testing services. If your doctor draws specimens in the office, instruct the doctor’s office to send the specimen to a participating GHS laboratory or request a courier pick-up. Also, ask your doctor to have a copy of your membership card accompany your specimen to the laboratory.

   You pay nothing for outpatient laboratory testing when you use a GHS facility. If you receive a bill in the mail, forward it to the Fund Administrator, United Administrative Services. If you have any questions about the GHS benefit, please contact GHS toll-free at 1-800-945-7708.
EXCLUSIONS, LIMITATIONS & NON-COVERED CHARGES

No benefits are provided for:

1. Services or supplies that are not medically necessary;
2. Any injury or sickness for which you are not treated by a legally qualified physician or surgeon;
3. Dentistry;
4. Eye refractions, or the fitting of glasses. Except, the Plan will pay for charges covered under the Medical Benefits portion of the Plan following cataract surgery.
5. Injury or illness occurring in the course of employment for wages or profit;
6. Any injury or illness for which you could receive benefits under any worker’s compensation law or occupational disease law or for which you could receive any settlement from a worker’s compensation insurer;
7. Any service unless a charge is made for such service which the Employee is required to pay;
8. Cosmetic services, except for photochemotherapy treatment of vitiligo for those under age 21 (There will be a $5,000. limit for this treatment.);
9. Experimental or investigational services;
   a) Experimental or Investigational Services. Treatment, procedures, equipment drugs, devices or supplies (hereinafter called "services") that are, in the Board of Trustees judgment, experimental or investigational. Services are considered experimental or investigational if:
      (1) They require but have not received approval of the U.S. Food & Drug Administration; or
      (2) They have not been the subject of a favorable study published in peer review medical literature. Peer review medical literature means a U.S. scientific publication that requires that manuscripts be submitted to acknowledged experts inside and outside the editorial office before publication for their considered opinions or recommendations regarding publication of the manuscript; or
      (3) They are determined by the Board of Trustees, after consultation with medical advisors, to be in research status and not accepted as a proper course of treatment.
10. Physical examinations;
11. Non BlueCross PPO contract hospital charges for well baby care;
12. Confinement in a U.S. Government hospital or any surgical, medical, or other treatment, services or supplies received in or from such a hospital, or for any confinement, services or supplies furnished without charge or reimbursed by the Federal Medicare Plan, state or other governmental program or for which no charge is made that the Employee or any of his/her Dependents is required to pay;
13. Orthotics unless medically necessary;
14. Any hospitalization which is primarily for custodial care not involving medical treatment;
15. Family Planning: Services and supplies for artificial insemination, in vitro fertilization, infertility treatment, or surgery to reverse elective sterilization;
16. Radial keratotomy;
17. Any treatment, services, appliances or surgery related to treatment of temporomandibular joint (TMJ) pain or syndrome (the temporomandibular joint is the joint between the temple and the jaw), as either a medical or dental expense unless pre-approved;
EXCLUSIONS, LIMITATIONS & NON–COVERED CHARGES

18. Services related to sex change procedures and any resulting compilations;

19. Penile implants unless required as a result of injury or an organic disorder;

20. Any service or supply relating to any evaluation, treatment or therapy involving the use of high-dosage chemotherapy and adjuvant autologous bone marrow transplant, autologous peripheral stem cell rescue, or autologous stem cell rescue for any disease other than acute lymphocytic leukemia and acute non-lymphocytic leukemia, Hodgkins' disease, non-Hodgkins' lymphoma, neuroblastoma, or germ-cell malignancies; or

21. Any home health care, except:
   a. The Plan will cover the medical component of home health care provided as part of hospice due to personal injury or sickness; and
   b. The Plan will cover the medical component of home health care as approved by Blue Cross in lieu of hospitalization due to personal injury or sickness.

22. Losses that are due to war or any act of war, whether declared or undeclared.

23. Hearing aids, their fitting or repair or hearing tests.

24. Family Planning services and supplies for artificial insemination, in-vitro fertilization, or surgery to reverse elective sterilization are not covered.

25. Any charges not specifically listed as covered charges are excluded.
DENTAL BENEFITS

SELF-FUNDED DENTAL BENEFITS

FOR CATEGORY 1 AND 2 EMPLOYEES AND DEPENDENTS

Dental Expense Benefits

If you or your Dependent incur Covered Dental Charges, this Plan will pay for the expenses actually incurred, but not to exceed the percentages of Usual, Customary and Reasonable Charges when performed by a legally qualified dentist for oral examinations and treatment of accidentally injured or diseased teeth and supporting bone or tissue.

Preferred Provider Dentists

Under this plan you are free to use any dentist. However, the Trustees have negotiated lower charges with certain dentists through DentiNex, called "preferred providers." The network of preferred providers is called "Dental Preferred Provider Organization" or "Dental PPO". Because the Plan saves money when you use a preferred provider dentist, you, as a participant also save money when you use a preferred provider dentist.

Charges incurred at a PPO Dentist are paid at the In-Network level of 100% of the Contract Rate for Class I services, 80% of the Contract Rate for Class II services and 60% of the Contract Rate for Class III services. Class III Services are subject to a $25 per person per year deductible.

A list of preferred provider dentists is provided to you automatically, free of charge, as a separate document.

Obtaining services from a preferred provider dentist does not necessarily mean the services will be covered. Services which are not covered by the Plan are excluded regardless of where or by whom services are provided.

Non-PPO Dentist

Charges incurred at a Non-PPO Dentist will be paid at the Out-of-Network benefit level of 100% of Usual, Customary and Reasonable Charges for Class I Services, 80% of Usual, Customary and Reasonable Charges for Class II Services and 60% of Usual, Customary and Reasonable Charges for Class III Services. Class III Services are subject to a $25 per person per year deductible.

Usual, Customary and Reasonable Charges are charges that the Fund Administrator determines fall within a range of those most frequently made for services, supplies and treatments in our service area by those who provide them. If you receive a covered service that costs more than this Usual, Customary and Reasonable Charge, the Plan will pay benefits based only on the amount considered Usual, Customary and Reasonable.

Alternate Courses of Treatment

If alternate procedures, services, or courses of treatment may be performed for the treatment of the injury or disease concerned or to accomplish the desired result, the amount included as Covered Dental Expense will not exceed the Usual, Customary and Reasonable Charge for the least expensive procedure, service, or course of treatment which, as determined by the Fund Administrator, will produce a professionally adequate result.

The benefits are subject to the Definitions, Exclusions, and Limitations of this booklet.

Pre-Estimation of Costs

Pre-estimation of treatment is requested for claims $300 and over.
DENTAL BENEFITS

After the attending Dentist's statement with pre-estimation of costs has been returned to your dentist, you should discuss the computations with him/her.

The Fund Administrator as a condition for payment for services, may require that reasonable evidence of the extent or character of services be submitted or that you be examined by a dental consultant retained by the Fund Administrator in or near your community of residence.

Maximum Benefits

Benefits are payable up to a maximum of $1,500 per person each calendar year, orthodontics up to $1,000 per person for lifetime.

Covered Dental Services

"Covered Dental Services" shall be deemed to have been incurred on the date the dental service is performed. Covered dental services are organized into four (4) "classes" that start with diagnostic preventative care and advance into specialized dental procedures.

Class I Services - Diagnostic/Preventative Services

1. Oral examinations, including scaling and cleaning of teeth, but not more than four (4) examinations or scaling and cleaning in any period of twelve (12) consecutive months;

2. Topical application of sodium or stannous fluoride, four (4) times in each period of twelve (12) consecutive months, but only if the insured family member has not yet attained the age of fifteen (15) years;

3. Bite wing X-rays.

Class I Services will be covered at 100% of the Usual, Customary and Reasonable Charges. No deductible applies.

Class II - Basic Services

1. Dental X-rays - other than bitewing.

2. Extractions.

3. Oral Surgery, including excision of impacted teeth.

4. Fillings.

5. General anesthetics administered in connection with oral surgery or other covered dental services.

6. Prescribed drugs, premedication or analgesia (nitrous oxide).

7. Injections of antibiotic drugs by the attending dentist.

8. Space maintainers.

9. Treatment of periodontal and other diseases of the gums and tissues of the mouth.

10. Endodontic treatment, including root and canal therapy.

Class II Services will be covered at 80% of the Usual, Customary and Reasonable Charges. No deductible applies.
DENTAL BENEFITS

Class III - Major Services

1. The initial installation (including adjustments during the six-month period following installation) of full or partial removable dentures or fixed bridgework.

2. The replacement, or alteration of, full or partial dentures, or fixed bridgework which is necessary because of:
   
   (a) oral surgery resulting from an accident; or

   (b) oral surgery for repositioning muscle attachments or for removal of a tumor, cyst, torus or redundant tissue, but only if this occurs after the protected person or Dependent has become insured under this provision and the replacement or alteration is completed within twelve (12) months after such surgery.

3. The replacement of a full denture which is necessary because of:
   
   (a) structural change within the mouth, but only if more than five (5) years has elapsed since the initial placement;

   (b) the initial placement of an opposing full denture, but only after the protected person or Dependent has been covered under this provision for at least two (2) years; or

   (c) the prior installation of an immediate temporary denture, but only within twelve (12) months of the installation of the temporary.

4. Replacement of, or addition of teeth to, an existing partial or full removable denture or fixed bridgework by a new denture or by a new bridgework, but only if
   
   (a) the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while insured under this provision and after the existing denture or bridgework was installed; or

   (b) the existing denture or bridgework was installed at least five (5) years prior to its replacement, and the existing denture or bridgework cannot be made serviceable.

5. The replacement of a crown restoration, provided the original crown was installed more than five (5) years prior to the replacement.

6. Inlays, gold fillings, crowns, including precision attachments for dentures.

7. Repair or recementing of crowns, inlays, bridgework, or dentures or relining of dentures.

Class III Services will be covered at 60% of the Usual, Customary and Reasonable Charges, subject to a $25 per person per year deductible.

Class IV - Orthodontic Services

Orthodontic benefits, which include orthodontic care, treatment, services and supplies (except for missing primary teeth) including correction of malocclusion, will be provided to employees and their eligible Dependents.

Class IV Services will be covered at 60% of the Usual, Customary and Reasonable Charges subject to a $25 per person per year deductible.

The maximum lifetime amount payable for orthodontic benefits is $1,000 per person.
DENTAL BENEFITS

Exclusions and Limitations

Exclusions:

1. Services for any injury or illness occurring in the course of employment for wages or profit; services for any injury or illness covered by Workers' Compensation laws; services for any injury or illness compensable under Employer's Liability Laws; services which are provided to the eligible patient by any federal or state government agency or are provided without cost to the eligible patient by any municipality, county, or other political subdivision.

2. Services with respect to congenital or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons.

3. Expenses incurred after termination of insurance except for prosthetic devices (including bridges and crowns) which were fitted and ordered prior to termination and which are delivered to you or your insured dependent within thirty (30) days after the date of termination.


5. Facings on pontics or crowns posterior to the second bicuspid.

6. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves, and other tissues.

7. Charges for cost of replacement and/or repairs of an orthodontic appliance furnished in whole or in part under this Plan.

8. Surgical procedures for correction of malalignment of teeth and/or jaws.

9. Charges for replacement of lost or stolen appliances, dentures or bridgework.

10. Expenses covered by any other provision of this Plan.

11. Charges for completion of claims forms.

12. Charges for dental appointments that are not kept.

13. Experimental procedures.

14. Charges due to war or any act of war, whether declared or undeclared.

15. Any service unless a charge is made for such service which the employee is required to pay.

Limitations:

The benefits as outlined are subject to the following limitations:

1. X-rays: Complete mouth X-rays are provided only once in a three (3) year period, unless special need is shown.

2. Prophylaxis: Prophylaxis (cleaning and scaling) including fluoride treatment for children is covered not more than four (4) times during any period of twelve (12) consecutive months.

3. Prosthodontics: Replacements will be made of an existing prosthodontic appliance only if it is unsatisfactory and cannot be made satisfactory. Prosthodontic appliances (including partial and complete dentures, crowns and bridges) will be replaced only after five (5) years have elapsed following any prior provision of such appliances.

4. In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, the Plan will pay the applicable percentage of the lesser fee. The patient is responsible for the remainder of the dentist's fee.
DENTAL BENEFITS

5. Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by this Plan. However, if implants are provided along with a covered prosthodontic appliance, the Plan will allow the prosthodontic appliances when the prosthetic appliance is completed. The Plan will not pay for any replacement for five (5) years following the completion of the service.

Claim Disputes

MENTAL HEALTH BENEFITS

Mental Health benefits provided by PacifiCare Behavioral Health are provided to self-Funded, PacifiCare and Health Net enrolled participants only. Kaiser participants receive Mental Health Benefits from Kaiser.

SCHEDULE OF MENTAL HEALTH BENEFITS

<table>
<thead>
<tr>
<th>Inpatient Deductible</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Per Admission Fee</td>
<td>Same as Medical Plan</td>
</tr>
<tr>
<td>Impatient, Partial and Day Treatment</td>
<td>30 Days per calendar year* covered at 100% after any applicable admission fee</td>
</tr>
</tbody>
</table>

*Days to be determined based on the following ratios:

| Inpatient Treatment - | 1 Day |
| Residential Treatment - | 70% of 1 Day |
| Day Treatment - | 60% of 1 Day |

Outpatient Mental Health

| 30 Visits | $5 co-payment per visit |

SERIOUS MENTAL ILLNESS BENEFITS

<table>
<thead>
<tr>
<th>Inpatient Deductible</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Per Admission Fee</td>
<td>Same as Medical Plan</td>
</tr>
<tr>
<td>Impatient, Partial and Day Treatment</td>
<td>Unlimited days covered at 100% after any applicable admission fee</td>
</tr>
<tr>
<td>Annual Maximum Benefit for Inpatients Treatment</td>
<td>None</td>
</tr>
<tr>
<td>Outpatient Mental Health Treatment</td>
<td>Unlimited Visits</td>
</tr>
<tr>
<td>$5 co-payment per visit</td>
<td></td>
</tr>
</tbody>
</table>

**Lifetime Dollar Maximum for Parity Diagnosis:** Applied to Medical Plan lifetime dollar maximum benefit.

Pre-Authorization is required for all Inpatient and Outpatient and Serious Mental Illness benefits.

Serious Mental Illness Diagnosis include: Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, Panic Disorder, Obsessive-Compulsive Disorder, Pervasive Developmental Disorders (Autism), Anorexia, Bulimia Nervosa, Severe Emotional Disturbances of Children (SED).
CHEMICAL DEPENDENCY BENEFITS

Chemical Dependency Benefits are provided to all participants and their eligible dependents regardless of their medical plan chosen by PacifiCare Behavioral Health.

SCHEDULE OF CHEMICAL DEPENDENCY BENEFITS

All levels of chemical dependency care includes detox.

- $25,000 Annual Maximum,
- $0 copay and covered at 100%
- $35,000 Lifetime Maximum

Pre-Authorization is required for all Chemical Dependency Benefits. Contact PacifiCare Behavioral Health 24 hours a day, 7 days a week toll-free at: 1-877-225-2267.
MEMBER ASSISTANCE PROGRAM (MAP) BENEFITS

The Member Assistance Program (MAP) is provided to all participants and their eligible dependents by PacifiCare Behavioral Health.

WHAT IS A MEMBER ASSISTANCE PROGRAM (MAP)?

A MAP is a free, confidential counseling and referral service designed to help you and your household members resolve personal problems that may be interfering with work or home life. PacifiCare Behavioral Health’s staff is experienced with the many problems facing union members, so they can talk your language.

WHAT PROBLEMS CAN MY MAP HELP ME WITH?

Just about anything. MAP programs focus on the following problems:

- Alcohol and drug abuse
- Anger management
- Child and elder care
- Debt management
- Domestic violence
- Emotional distress
- Job stress
- Legal assistance
- Relationship problems

WHO’S ELIGIBLE?

You and any member of your household may call your MAP for services. Dependents living away from home may also access your MAP services.

HOW DO I ACCESS MY BENEFITS?

The first step toward handling your problems starts with a single toll free phone call to your MAP hot line. It’s staffed by professional counselors, 24 hours a day, 365 days a year. The phone counselor will listen carefully to your concern or issue and help you assess the situation, then will suggest ways to resolve the problem.

If more than just phone counseling is required, you may be referred to a licensed counselor, or other behavioral health practitioner. You may also be referred to a community resource, such as a support group. If a health problem is contributing to your situation, you could be referred to a medical professional.

IS THIS REALLY CONFIDENTIAL?

Yes! Your phone call, website visits, e-mails, any referrals you receive-everything you tell them will be kept strictly confidential (as required by law).

PACIFICARE BEHAVIORAL HEALTH
Toll Free: 1-877-225-2267
24 hours a day, 7 days a week
VISION CARE BENEFITS

Vision care benefits are provided through Vision Services Plan ("VSP"). Before making an appointment, contact VSP at 1-800-877-7195 to obtain a list of member doctors. Contact the VSP member doctor and make an appointment. Identify yourself as a VSP member and provide the doctor's office with the covered member's social security number and the Trust's name, i.e., I.B.E.W. / NECA Sound and Communications Health and Welfare Plan. The member doctor will call the Fund Administrator's Office or VSP to verify your eligibility and plan coverage. If you are not eligible the doctors office will call to explain why and discuss available options.

When services are received from a VSP doctor, reimbursement is made directly to the doctor. The patient will have no out-of-pocket expenses other than optional items that are selected that the group does not cover. Optional items include, but are not limited to, oversize lenses, coated lenses, no-line multifocal lenses, or a frame which exceeds the plan allowance.

If services are obtained from a non-member doctor and/or dispensing optician, the bill is submitted to Vision Service Plan at: P.O. Box 997100, Sacramento, CA 95899 and will be reimbursed according to the schedule below.

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>$45.</td>
</tr>
<tr>
<td>Lined Bifocal Lenses</td>
<td>$65.</td>
</tr>
<tr>
<td>Frames</td>
<td>$47.</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>$45.</td>
</tr>
<tr>
<td>Lined Trifocal Lenses</td>
<td>$85.</td>
</tr>
<tr>
<td>Lenticular Lenses</td>
<td>$125.</td>
</tr>
<tr>
<td>Contacts</td>
<td>$105.</td>
</tr>
</tbody>
</table>

How Often Are Services Available?

1. **Vision Examination**: Every twelve (12) months.
2. **Lenses**: Every twenty-four (24) months only if needed.
3. **Frames**: Every twenty-four (24) months only if needed.

BENEFITS OF THE VISION SERVICE PLAN

Vision Examination

The primary purpose of this vision care plan is to provide for professional vision examinations. Each covered person is entitled to an examination every twelve (12) months. The examination is a complete analysis of the visual functions, including the prescription of glasses where indicated.

If the patient selects a VSP panel doctor for the examination, there is no cost.

Examination Procedures

(Each test may not be indicated for every patient.)

1. **Vision Survey** - If the patient has no specific complaint but indicates a desire for a brief routine check-up, the doctor may, at his/her discretion, perform a vision survey.

2. **Vision Analysis** - If the doctor performs a complete vision analysis, it should include, but not be limited to, the following:
   a. Visual acuity at 20 feet for each eye and for both eyes.
   b. Visual acuity at 16 inches for each eye and for both eyes.
   c. Cover test at 20 feet and 16 inches.
   d. Pupillary reflexes.
VISION CARE BENEFITS

e. Test of eye movements.
f. Ophthalmoscopy.
g. Retinoscopy.
h. Refraction.
i. Coordination measurements--far and near.
j. Additional tests as indicated such as tonometry, visual fields, biomicroscopy color vision, depth perception, etc.

Corrective Lenses

When the vision examination indicates the need for corrective lenses, the VSP doctor will order the lenses from an approved ophthalmic laboratory.

The VSP doctor will verify the accuracy of the finished lenses when they are returned from the laboratory to make sure they comply with the prescription as written.

The VSP plan provides any necessary lenses including single vision, bifocal, trifocal, or other more complex and expensive lenses necessary for the patient's visual welfare.

Patients sometimes select lenses or lens characteristics that are not necessary for their visual welfare but are desired for cosmetic reasons. Examples are oversize lenses when large frames are selected, blended bifocals, or progressive lenses. The patient can have such lenses but is required to pay the additional cost.

Frames

You are fully covered for frames up to your allowance of ONE-HUNDRED AND TWENTY DOLLARS ($120) purchased from a VSP network doctor. This allowance provides coverage for a wide selection of frames. In fact, your VSP benefit provides guaranteed savings whether you choose a frame that is covered in full or one that exceeds the plan's allowance. If you choose a frame valued at more than the plan's allowance, you will receive a twenty percent (20%) discount on the amount over your allowance. Have your doctor help you choose the best frame for you based on your needs.

Value-Added Discounts

Your plan also provides a twenty percent (20%) discount on additional pairs of prescription glasses (lenses and frame), including prescription sunglasses. Simply return to the same VSP doctor who performed your last covered eye exam within twelve (12) months from the date of the exam.

Contact Lenses

Medically necessary contact lenses may be prescribed by a VSP doctor for certain conditions. A VSP doctor must receive prior approval from VSP for medically necessary contact lenses. If the request is approved, then the contact lenses are fully covered by VSP. If you go to a non-member provider and prior approval is secured, VSP will pay up to TWO-HUNDRED AND TEN DOLLARS ($210).

Because of the complex nature of this type of benefit, it is sometimes necessary for the patient to pay some additional cost. These problems are resolved on a case-by-case basis.

When the patients choose contact lenses, there will be an allowance of ONE-HUNDRED AND TWENTY DOLLARS ($120) toward the cost of the contacts and the exam is covered in full.
VISION CARE BENEFITS

Exclusions and Limitations

Extra Cost:

This plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, there will be an extra charge:

1. Blended lenses.
2. Contact lenses (except as noted elsewhere herein).
3. Oversize lenses.
5. Coated lenses.
7. A frame that costs more than the Plan allowance.
8. Certain limitations on low vision care.
10. Optional cosmetic processes.
11. UV (ultraviolet) protected lenses.

Not Covered:

There is no benefit for professional services or materials connected with any of the following:

1. Orthoptics or vision training, and any associated supplemental testing.
2. Plano lenses.
3. Two pair of glasses in lieu of bifocals.
4. Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
5. Medical or surgical treatment of the eyes.
6. Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.
7. Services or materials for any injury or illness occurring in the course of employment for wages or profit; services or materials for any injury or illness covered by Workers' Compensation Law or similar legislation, or obtained through or required by any government agency or program whether federal, state, or any subdivision thereof, except VSP will pay benefits if the State of California makes a charge for these benefits and if the service is provided by the State of California.
VISION CARE BENEFITS

Grievance System

If you have a complaint or grievance regarding VSP service or claim payment, you may communicate your grievance to VSP by calling the VSP Customer Service Department toll free at (800) 877-7195, Monday through Friday, 6:00 a.m. to 6:00 p.m., Pacific Standard Time. You may also file a complaint or grievance in writing with VSP at 3333 Quality Drive, Rancho Cordova, California 95670. If you have an emergency grievance or your grievance has not been satisfactorily resolved by VSP, you may contact the California Department of Corporations, Health Plan Division toll free at (800) 400-0815 or visit the Department's website http://www.corp.ca.gov. The hearing and speech impaired may contact the Department toll free at (800) 435-2929 or (888) 877-5378.
SUMMARY PLAN DESCRIPTION

Name of Plan:

This Plan is known as the I.B.E.W. / NECA Sound and Communications Health and Welfare Trust.

Name, Address, and Telephone Number of Joint Board of Trustees / Plan Sponsor:

This Plan is sponsored by a joint labor-management Board of Trustees, the name and address of which is:

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>Physical Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board of Trustees</td>
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</tr>
<tr>
<td>of the I.B.E.W. / NECA</td>
<td>of the I.B.E.W. / NECA</td>
</tr>
<tr>
<td>Sound and Communications</td>
<td>Sound and Communications</td>
</tr>
<tr>
<td>Health and Welfare Trust</td>
<td>Health and Welfare Trust</td>
</tr>
<tr>
<td>P.O. Box 5057</td>
<td>1120 S. Bascom Avenue</td>
</tr>
<tr>
<td>San Jose, CA 95150-5057</td>
<td>San Jose, CA 95128-3590</td>
</tr>
</tbody>
</table>

Telephone: (408) 288-4400

Employer and Plan Identification Numbers:

The employer identification number and plan number assigned to the Plan Sponsor by the Internal Revenue Service are:

Employer Identification Number: 77-0234638.
Plan Number: 501.

Type of Plan:

This Plan is a Health and Welfare Benefit Plan which provides life insurance, accidental death and dismemberment, short-term disability, medical, dental, vision and member assistance program benefits.

Type of Administration:

This Plan is administered by the joint Board of Trustees with the assistance of United Administrative Services, a contract administration organization.

Name, Address, and Telephone Number of Fund Administrator:

<table>
<thead>
<tr>
<th>Mailing Address</th>
<th>Physical Address</th>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

Telephone: (408) 288-4400
SUMMARY PLAN DESCRIPTION

Name and Address of Agent for Service of Process:

The Board of Trustees has designated the following attorney as agent for the purpose of accepting service of legal process on behalf of the Trust Fund, although the trustees may be served directly.

Mark H. Lipton
Lipton & Hallbauer
1380 Lead Hill Blvd
Suite #106
Roseville, CA 95661-2941

Names, Titles and Addresses of Joint Board of Trustees:

<table>
<thead>
<tr>
<th>Labor Trustees:</th>
<th>Management Trustees:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dan Chivello</td>
<td>Rick Jensen</td>
</tr>
<tr>
<td>I.B.E.W. Local No. 595</td>
<td>JM Electric</td>
</tr>
<tr>
<td>6250 Village Parkway</td>
<td>400 Griffin Street</td>
</tr>
<tr>
<td>Dublin, CA 94568-2449</td>
<td>Salinas, CA 93901-4344</td>
</tr>
<tr>
<td>John O’Rourke</td>
<td>Doug Lung</td>
</tr>
<tr>
<td>I.B.E.W. Local No. 6</td>
<td>NECA – Santa Clara Valley Chapter</td>
</tr>
<tr>
<td>55 Filmore Street</td>
<td>P.O. Box 28899</td>
</tr>
<tr>
<td>San Francisco, CA 94117-3545</td>
<td>San Jose, CA 95159-8899</td>
</tr>
<tr>
<td>Bob Tragni</td>
<td>Ben Wadsworth</td>
</tr>
<tr>
<td>I.B.E.W. Local No. 332</td>
<td>River City Communications Corp.</td>
</tr>
<tr>
<td>2125 Canoas Garden Avenue</td>
<td>643 W. Stadium Lane</td>
</tr>
<tr>
<td>Suite #100</td>
<td>Sacramento, CA 95834-1100</td>
</tr>
<tr>
<td>San Jose, CA 95125-1393</td>
<td></td>
</tr>
</tbody>
</table>

Description of Collective Bargaining Agreements:

This Plan is maintained pursuant to the terms of collective bargaining agreements between various National Electrical Contractors Association Chapters and other contractors, and various I.B.E.W. Local Unions. The collective bargaining agreements provide that employer parties thereto will make the required contributions to this Fund for the purpose of enabling the Employees working under the collective bargaining agreements to participate in the benefits provided by the Trust Fund. Copies of the collective bargaining agreements can be obtained from the participating I.B.E.W. Local Unions. You may receive from the Fund Administrator upon written request, information regarding whether a particular employer is a Plan sponsor and, if so, the sponsor’s address.

Eligibility, Termination of Eligibility and Benefits:

This benefit booklet provides a description of benefits, eligibility and termination of eligibility requirements. If at any time you are unable to locate your benefit booklet, an additional copy may be obtained from the Fund Administrator, or any participating local union office.

Source of Contributions:

This Plan is funded through employer contributions, the amount of which is specified in the Collective Bargaining Agreements or, in the case of Category 2 Subscription / Participation Agreements, the amount is specified by the Board of Trustees. Also, self-payments by Employees and Dependents are permitted as outlined in the "Self-Payment" section of this benefit booklet. The amount of self-payment is determined by the Board of Trustees from time to time.
SUMMARY PLAN DESCRIPTION

Organizations Providing Benefits, Funding Media and Type of Administration:

The names and addresses of all of the organizations providing benefits and their roles (i.e., whether they are responsible for the administration of the benefit plan and whether benefits are guaranteed under an insurance policy) are set forth below.

Medical, Dental and Short-Term Disability

Claims arising from the self-funded medical and dental plans for employees and dependents and the short-term disability benefit employees are paid directly from Trust assets, although a premium is paid to an insurance company for specific stop loss insurance coverage for self-funded medical benefits.

Preferred Provider Organization

The Trust has entered into a contract with a preferred provider organization that can be used by Employees and Dependents enrolled in the Self-Funded Medical Plan. The Trust is responsible for paying claims submitted by providers. The preferred provider organization is responsible for the administration of contracts with physicians, specialists, hospitals and clinics. The preferred provider organization currently is:

- Blue Cross of California
- BC Life and Health Insurance Company
- 21555 Oxnard Street
- Woodland Hills, CA 91367

Case Management and Utilization Review Organization

The Trust has entered into a contract with a case management and utilization review organization that reviews the setting, necessity and quality of health care provided to Employees and Dependents enrolled in the Self-Funded Medical Plan. The Trust pays the case management and utilization review organization a fee for the services it provides. The case management and utilization review organization currently is:

- Blue Cross of California
- BC Life and Health Insurance Company
- 21555 Oxnard Street
- Woodland Hills, CA 91367

Health Maintenance Organizations

Employees and Dependents have the option of selecting medical coverage from three health maintenance organizations. The medical benefits are insured and provided under contracts between the Trust and Health Net of California, Inc., PacifiCare of California and the Kaiser Foundation Health Plan. Health Net of California, Inc., PacifiCare of California and the Kaiser Foundation Health Plan are responsible for administering their own plans and paying the claims.

- Kaiser Foundation Health Plan, Inc.
  Northern California Region
  1800 Harrison Street, 9th Floor
  Oakland, CA 94612

- Health Net of California, Inc.
  155 Grand Avenue, 3rd Floor
  Oakland, CA 94612

- PacifiCare of California
  5701 Katella Avenue
  Cypress, CA 90630
SUMMARY PLAN DESCRIPTION

**Mail Order Prescription Drug Program**

The mail order prescription drug program for Employees and Dependents enrolled in the Self-Funded Medical Plan is provided by Medco Rx Services. The Trust is responsible for paying the mail order prescription drug claims. A fee is paid to Medco Rx Services for administering the program.

Medco Rx Services  
P.O. Box 3959  
Spokane, WA 99220

**Prescription Drug Program**

The prescription drug program for Employees and Dependents enrolled in the Self-Funded Medical Plan is provided by Medco Rx Services. The Trust is responsible for paying the prescription drug claims. A fee is paid to Medco Rx Services for administering the program.

Medco Rx Services  
P.O. Box 3959  
Spokane, WA 99220

**Vision Plan**

Vision benefits are provided for Employees and Dependents by Vision Service Plan. The Trust is responsible for paying the claims. A fee is paid to Vision Service Plan for administering the vision plan.

Vision Service Plan  
3333 Quality Drive  
Rancho Cordova, CA 95670

**Life and Accidental Death and Dismemberment Insurance**

The life and accidental death and dismemberment insurance benefits for Employees are provided by Standard Insurance Company. The benefits are provided and insured under group insurance contracts between the Trust and Standard Insurance Company. Standard Insurance Company is responsible for administering the plans and paying the claims.

Standard Insurance Company  
920 SW Sixth Avenue  
Suite #1002  
Portland, OR 97204

**Mental Health, Chemical Dependency and Member Assistance Program Benefits**

Mental Health, Chemical Dependency and Member Assistance Program benefits are provided and insured under a group insurance contract between the Trust and PacifiCare Behavioral Health. PacifiCare Behavioral Health is responsible for administering the plan and paying the claims.

**Laboratory Preferred Provider Organization**

The Trust has entered into a contract with a Laboratory preferred provider organization that can be used by Employees and Dependents enrolled in the Self-Funded Medical Plan. The Trust is responsible for paying claims submitted by providers. The preferred provider organization is responsible for administration of contracts with laboratories. The preferred provider organization currently is:

Group Health Systems  
P.O. Box 40  
McArthur, CA 95056
SUMMARY PLAN DESCRIPTION

Plan Year:

This Plan is on a calendar year basis with the Plan Year ending December 31.

Statement of ERISA Rights:

As a participant in the I.B.E.W. / NECA Sound and Communications Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Fund Administrator's Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Fund Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Fund Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue group health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this benefit booklet on the rules governing your COBRA continuation coverage rights.

Demonstrate Creditable Coverage to Reduce or Eliminate Preexisting Condition Exclusion Period

Demonstrate creditable coverage under another group health plan in order to reduce or eliminate the preexisting condition exclusion period under your group health plan. You should be provided with a certificate of creditable coverage, free of charge, from a group health plan or health insurance issuer at the following times: (1) when you lose, or would lose in the absence of COBRA continuation coverage, coverage under the plan; (2) when your COBRA continuation coverage ceases; and (3) when you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion in your coverage for six (6) months after your enrollment date.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to One Hundred and Ten Dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Fund Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Fund Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act of 1996, or if you need assistance in obtaining documents from the Fund 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.

**Relationship Between Plan and Providers of Medical Services**

No health care provider is an agent or representative of the Plan or of the Board of Trustees. The Plan does not control or direct the provision of health care services and/or supplies to Plan participants and beneficiaries by anyone. The Plan makes no representation or guarantee of any kind concerning the skills or competency of any health care provider. The Plan makes no representation or guarantee of any kind that any provider will furnish health care services or supplies that are malpractice-free.

The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the Plan. The statement also applies to all entities (and their agents, employees and representatives) which contract with the Plan to offer preferred provider networks or other health-related services or supplies to participants and beneficiaries, including but not limited to Medco Rx Services, Blue Cross PPO, Kaiser Permanente, Group Health Systems, Health Net, PacifiCare, PacifiCare Behavioral Health, Standard Insurance Company, and Vision Service Plan.

**Plan Amendment and Termination:**

The Plan has been established for the exclusive benefit of employees and their eligible dependents. The Plan is intended to be maintained indefinitely. However, the Board of Trustees reserves the right to amend or terminate the Plan at any time. Additionally, the Plan may terminate by agreement of the bargaining parties or by operation of law. In the event of termination, any money remaining after payment of all Plan expenses shall be used to continue the benefits provided under the Plan in accordance with rules adopted by the Board of Trustees. In no event will termination result in reversion of any of the Plan's assets to contributing employers. The Board of Trustees may amend the Plan from time to time as to eligibility requirements, benefit structures and selection of service providers. Plan amendments may reduce or eliminate benefits provided under the Plan.
GENERAL PROVISIONS

Processing and Payment of Claims

Hospital, surgical, medical, short-term disability, and dental claims should be reported promptly to the Administrative Office, which has the forms for submitting proof of claim.

Self-Funded Medical Plan claims are paid by the Fund Administrator. Therefore, your claim forms and bills should be submitted to this office. Claims personnel are available to answer any questions you may have. However, oral information and answers are not binding upon the Trustees and cannot be relied on in any dispute concerning your benefits.

Claims should be reported promptly to the Fund Administrator. Claims will be paid according to the Summary of Benefits, subject to any deductible. Remember that in certain cases you may apply the expenses incurred in the last three (3) months of one year against the deductible for the following calendar year.

The Plan will review each claim for approval or adjustment. After the claim is reviewed, and upon completion of the treatment, one of two actions will occur:

1. You will be reimbursed for the Plan’s share of the cost, provided benefits were not assigned; or
2. The provider will be reimbursed for the Plan’s share of the cost.

Claims received more than twelve (12) months after the expense is incurred will not be paid.

The Plan reserves the right and opportunity to examine the person whose injury or sickness is the basis of claim as often as it may reasonably require during pendency of the claim.

The Plan reserves the right to allocate the deductible amount to any eligible charges and to apportion the benefits to you and any assignees.

All assignments for payment of claims require original signature of the participant.

No action in a court of law shall be brought unless all administrative remedies provided in this Summary Plan Description have been exhausted as is required by ERISA. Furthermore, in determining eligibility for and the amount of benefits to be paid, the Board of Trustees shall have complete discretion in making said decision. Discretion as provided herein relates to factual determinations, interpretation of Plan provisions and any other decision required for benefit determinations.

How to File a Claim for Benefits Under the Self-Funded Plan

In order to help speed the processing of your claim, you must submit a signed claim form completed as follows:

1. Part I completed and signed by the participants.
   If an accident, you must give complete information as to date, time, and place.

2. Part II completed by the attending physician ONLY. (We do not need claim forms completed by the lab technologist, radiologist, or consulting physician.)
   a) Only one claim form is needed for a continuing illness every few months.
   b) A new claim form is required for each new illness and each accident.
   c) Identify all subsequent bills with your local union name and number.
   d) Assignment of benefit payment will only be honored upon the participant’s personal signature.

3. Claims received more than twelve (12) months after the expense is incurred will not be paid unless the Employee provides satisfactory evidence that he/she has remained continuously disabled from the
GENERAL PROVISIONS

inception of the disability absence through the date the application is received. Any claim for the short-term disability benefit which is not received by the Plan within sixty (60) days of the disability absence will not be paid.

How to File a Dental Claim

1. Obtain a claim form from your Union Office or Fund Administrator.
2. Complete the employee portion of the claim form.
3. Have your dentist complete his/her portion of the claim form.
4. Upon completion of the claim form, attach itemized bills and return your claim form to:

   **Mailing Address**
   Board of Trustees of the I.B.E.W. / NECA
   Sound and Communications Health and Welfare Trust
   P.O. Box 5057
   San Jose, CA 95150-5057

   **Physical Address**
   Board of Trustees of the I.B.E.W. / NECA
   Sound and Communications Health and Welfare Trust
   1120 S. Bascom Avenue
   San Jose, CA 95128-3590

5. If you have a question regarding your claim, you may telephone the Fund Administrator's Office at: (408) 288-4400.

Claims and Appeals Procedures

Claims should be filed with the Fund Administrator. Contact the Fund Administrator for forms and instructions for making a claim.

1. If a claim is denied or partially denied, you will be notified in writing and given an opportunity for review.

   **Concurrent Care Claims**
   If you have been approved for ongoing treatment or approved for a specific number of treatments, any reduction of such benefit shall be considered a denial of benefits. You will be notified in writing in advance of any reduction or termination of the benefits to allow you the opportunity to appeal and obtain a determination on review before the benefit is reduced or terminated.

   If you wish to extend the course of treatment beyond the period of time or the number of treatments previously approved, the request must be made twenty-four (24) hours before the approved treatment is to end. You will be notified within twenty-four (24) hours of the decision, whether the determination is adverse or not.

   **Pre-Service Claims**
   You will be notified of the determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstance, but no later than fifteen (15) days of receipt of the claim, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. If such extension is required, you will be sent written notice before the expiration of the initial fifteen (15) day period, stating the special circumstances requiring the extension and the date by which a decision on the claim can be expected. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you will be given at least forty-five (45) days from the receipt of the notice within which to provide the specified information.

   **Post-Service Claims**
   The notice of denial shall be given within thirty (30) days after the claim is filed, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. If such extension is required, you will be sent written notice before the expiration of the initial thirty (30) day period, stating the special circumstances requiring the extension and the date by which a decision on the claim can be expected. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension shall specifically describe the
required information, and you shall be given at least forty-five (45) days from the receipt of the notice within which to provide the specified information.

Disability Claims
The notice of denial shall be given within forty-five (45) days after the claim is filed, unless special circumstances beyond the control of the Plan require an extension of time for processing the claim. An extension of time not exceeding thirty (30) days may be necessary due to matters beyond the control of the Plan, in which case notice will be sent to you prior to the expiration of the forty-five (45) day period. If a decision cannot be rendered due to matters beyond the control of the Plan prior to the expiration of the thirty (30) day extension, the period for making a determination may be extended for up to an additional thirty (30) days, in which case notice will be sent to you prior to the expiration of the first thirty (30) day extension. Any notice of extension shall indicate the special circumstances requiring an extension of time, the date by which the Plan expects to render a benefit determination, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information necessary to resolve those issues. You will be given at least forty-five (45) days to provide the specified information, if any. The deadline for a decision to be rendered is tolled from the date on which the notification of the extension is sent to you until the date a response from you is received.

2. Written denial will give (a) specific reasons for denial, (b) a reference to the specific Plan provision on which the denial is based, (c) a description of any additional material or information necessary to complete the claim process and the reason why such material or information is needed, (d) an explanation of the Plan's claim review procedure, including a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review, (e) a statement of any internal rule or guideline that was relied upon, if any, when making the decision and that a copy of such internal rule or guideline will be provided free of charge upon request, and (f) if the denial was based on medical necessity or experimental treatment, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the claimant's medical circumstances will be provided free of charge upon request.

If your claim is not acted upon within a reasonable period of time, you may proceed to the review procedure stage, described below, as if the claim had been denied.

3. Review procedure:
   a) Where a claim has been denied or partially denied, you may appeal the denial and be given an opportunity for review.
   b) Within one hundred and eighty (180) days after you have received written notice that your claim has been denied, you or your representative may make a written request for review to:

   I.B.E.W. / NECA Sound and Communications Health and Welfare Plan
   P.O. Box 5057
   San Jose, CA 95150-5057

   Such a written request must include all grounds for appeal and supporting facts.
   c) A written request for review must set forth all the grounds upon which it is based, together with any supporting facts, including comments, documents and records, and any other matters which you feel support your claim, and this information will be considered in determining your appeal.
   d) Upon request and free of charge, you may have access to, and copies of, any relevant documents of the Trust or insurance company, including the name of the medical or vocational expert whose advice was obtained in connection with the appeal, without regard to whether the advice was relied upon in making the initial benefit determination.
   e) Your appeal will not be reviewed by the same individual who made the initial determination nor a subordinate of such person, and the initial determination will not be given any deference in deciding your appeal.
   f) A health care professional with the appropriate training and experience will be consulted in any appeal based in whole or in part on medical judgment, and such health care professional will be
neither the health care professional consulted in the initial determination nor the subordinate of such health care professional.

g) Within a reasonable time after receipt of your request for review for post-service claims, you will be notified as to the date, time, and place of the hearing by regular mail to the address as shown on your request for review.

h) You may be represented at such hearing by an attorney or any other representative of your choosing at your own cost and expense.

i) The Board of Trustees has full discretionary authority to interpret all Plan documents and to make all factual determinations concerning your claim.

4. Decision on review:

Pre-Service Claims

A decision will be made promptly and not later than thirty (30) days after the receipt of your request for review.

Post-Service Claims

A decision will be made promptly and not later than sixty (60) days after the receipt of your request for review.

Disability Claims

A decision will be made promptly and not later than forty-five (45) days after the receipt of your request for review.

The decision on review will be in writing and will include (a) specific reasons for the denial, (b) a reference to the specific Plan provisions on which the determination is based, (c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, (d) a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures, (e) a statement of your right to bring an action under ERISA Section 502(a), (f) the specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination, and (g) an explanation of the scientific or clinical judgment for the determination if the denial was based on medical necessity or other similar exclusion or limit.

The decision of the Board of Trustees on review shall be final. No lawsuit may be filed without exhausting the above review procedure. In any such lawsuit, the decision of the Board of Trustees will be subject to judicial review only for abuse of discretion. No legal action may be commenced or maintained against the Trust or Plan more than two (2) years after the claim has been denied.

No Vested Right to Benefits

Covered Employees or Dependents do not have a vested right to the benefits provided under the Plan. Benefits may be modified, reduced or eliminated in the future and any such change will apply to charges incurred for services or supplies on or after the effective date of the modification, reduction or elimination. The Plan will not pay benefits for charges incurred by a person after that person terminates participation in the Plan.

Conditional Payment

If a covered Employee or Dependent has medical expenses as a result of an injury or accident for which a third party is, or may be, held responsible, the Plan may make advance payments on behalf of such Employee or Dependent, subject to the Plan’s subrogation rights. Before any such payments will be conditionally made, the covered Employee or Dependent (or the Dependent’s legal guardian if the Dependent is a minor) shall execute an agreement that acknowledges and affirms (1) the conditional nature of the payments and (2) the Plan’s rights of subrogation, as provided for below.
GENERAL PROVISIONS

Subrogation

If a covered Employee or Dependent receives benefits from the Plan arising out of an injury or illness for which the Employee or Dependent (or the guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, such benefit payments shall be made on the condition and with the understanding that this Plan shall be reimbursed. Such reimbursement shall be made by the covered Employee or Dependent (or the guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the covered Employee or Dependent (or the guardian or estate) from: (1) any policy or contract from any insurance company or carrier, and/or (2) any recovery from a third party, plan, or fund as a result of a judgment or settlement.

This Plan shall be subrogated to all claims, demands, actions, and rights of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including the covered Employee's or Dependent's insurer) to the fullest extent permitted by law in the appropriate jurisdiction. The amount of such subrogation shall equal the total amount paid under this Plan arising out of the injury or illness for which the covered Employee or Dependent (or the guardian or estate) has, may have, or asserts a cause of action. In addition, this Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights under this section.

The covered Employee or Dependent shall do nothing to prejudice this Plan's rights to reimbursement or subrogation, and shall cooperate fully with the Plan in asserting and protecting the Plan's subrogation rights. The covered Employee or Dependent shall execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect this Plan's subrogation rights.

The covered Employee or Dependent shall notify the Fund Administrator in writing, of whatever benefits are paid under this Plan that arise out of any injury or illness that provides or may provide the Plan subrogation rights under this section.

The Plan shall pay out of proceeds actually recovered a proportional share of any reasonable fee incurred by the covered Employee or Dependent for attorney services in collecting from such third party or parties. The Plan shall have sole discretion to determine the reasonableness of such fees.

Failure to comply with the requirements of this section by the covered Employee or Dependent (or the estate or guardian) may result in forfeiture of benefits under this Plan.

Coordination of Benefits With Other Plan Benefits

This Plan has been designed to help you meet the cost of disease or injury. Since it is not intended that you receive greater benefits than the actual medical or dental expenses incurred, the amount of benefits payable under this Plan will take into account any coverage you have under other "plans," that is, the benefits under this Plan will be coordinated with the benefits of the other plans.

Specifically, in a calendar year, this Plan will always pay either its regular benefits in full, or a reduced amount which, when added to the benefits payable by the other plan or plans, will equal 100% of "allowable expenses:"

"Allowable expense" means any necessary, customary, and reasonable expense incurred while eligible for benefits under this Plan, part or all of which would be payable under any of the plans, but not any expenses contained in the list of exclusions.

"Plans" means any plan under which medical or dental benefits or services are provided by:

1. group insurance or any other arrangement of coverage for individuals in a group whether or not insured; or
2. Blue Cross, Blue Shield or any other pre-payment arrangement.
GENERAL PROVISIONS

Which Plan Pays First?

If both plans have a coordination of benefits provision, the plan that insures you as an Employee pays first. If you receive benefits as an Active Employee under one plan and as a Retiree or COBRA participant under another, the plan you have as an Active Employee pays first. If you are insured as an Employee under two (2) plans, the plan which has insured you longer is primary. If one plan does not have a coordination of benefits provision, that plan is always primary. If a Dependent child is covered under two plans, the plan of the parent whose birthday (month and day) is earlier in the year will pay its benefits first. If the parents of a Dependent child are divorced or legally separated, the plan of the parent with custody of the child pays its benefits first. If the parent with custody remarries, the order of payment is as follows:

1. Natural parent with whom the child resides.
2. Stepparent with whom the child resides.
3. Natural parent not having custody of the child.

This order of payment can change pursuant to a Qualified Medical Child Support Order.

A spouse or Dependent who:

a. is covered as an Employee, as well as a Dependent, will have any claims paid first as an Employee and any balance as a Dependent; and

b. each Dependent child of such Employee and spouse will be considered a Dependent of both for payment of any claim up to 100% of covered charges.

Qualified Medical Child Support Order

The Plan will comply with any medical child support order which meets the requirements of a Qualified Medical Child Support Order (QMCSO) under applicable Federal law as determined by the Fund Administrator. In order to be qualified, a medical child support order may not require the Plan to provide benefits to a person who is not otherwise eligible under the terms of the Plan, or to provide any form of benefit not otherwise provided under the terms of the Plan.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing the company to cover a child under the plan. Federal law requires that a medical child support order meet certain form and content requirements in order to be qualified. You may request a copy of the written procedure for determining whether a medical child support order is qualified, free of charge, from the Fund Administrator.

Medicare Coordination of Benefits

This Plan will pay benefits before Medicare in the following circumstances:

1. All claims for an Active Employee who is age sixty-five (65) or older.
2. All claims for Dependents of an Active Employee over age sixty-five (65).
3. The first thirty (30) months of treatment for end-stage renal disease received by any eligible person who is less than sixty-five (65) years of age.

An Active Employee is an individual working in the industry having contributions remitted to the Plan or an individual available for work and on the out-of-work list of a participating I.B.E.W. Local Union and/or an individual on the out-of-work list of a participating I.B.E.W. Local Union making self-payments for continued coverage. If you are over age sixty-five (65) and an Active Employee or the spouse of an Active Employee, you may elect Medicare as your primary coverage. If Medicare is elected as primary, medical coverage under this Plan will cease.
GENERAL PROVISIONS

The Plan will coordinate benefit payments and will observe assignment and benefit recovery procedures under any state plan of medical assistance approved under Title XIX of the Social Security Act in the manner and to the extent required by federal law.

List of Participating Facilities and Dentists

The Blue Cross PPO includes an extensive network of hospitals, physicians and ancillary healthcare providers. The dental plan includes a network of participating dentists who have agreed by contract to reduced rates and fee ceilings for both the dental plan and the patient. A list of participating providers is furnished automatically, free of charge, to you as a separate document.

Policies

This benefit booklet describes the principal features of the Plan. The complete terms of the group insurance coverage for Life Insurance, Accidental Death & Dismemberment, Vision Service Plan, Kaiser Permanente, Health Net, PacifiCare, PacifiCare Behavioral Health and Standard Insurance Company are set forth in master group insurance policies issued by each of these providers.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Disclosure

The Plan and any Business Associate, as defined below, will disclose your Protected Health Information to the Board of Trustees only to permit the Board of Trustees to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. §§ 160-64). Any disclosure to and use by the Board of Trustees of your Protected Health Information will be subject to and consistent with this Section.

Restrictions on Use and Disclosure of Protected Health Information

1. The Board of Trustees will not disclose your Protected Health Information, except as permitted or required by the Notice of Privacy, Accidental Death & Dismemberment, Vision Service Plan, Kaiser Permanente, Health Net, PacifiCare, PacifiCare Behavioral Health and Standard Insurance Company are set forth in master group insurance policies issued by each of these providers.

2. The Board of Trustees will ensure that any agent, including any subcontractor, to who it provides your Protected Health Information agrees to the restrictions and conditions of the Plan Documents, including this Section, with respect to your Protected Health Information.

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

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

5. The Board of Trustees will make Protected Health Information available to the Plan Participant who is the subject of the information in accordance with 45 C.F.R. § 164.524.

6. The Board of Trustees will make your Protected Health Information available for amendment and will on notice amend your Protected Health Information, in accordance with 45 C.F.R. § 164.526.

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

8. The Board of Trustees will make its internal practices, books, and records, relating to its use and disclosure of your Protected Health Information, available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 C.F.R. §§ 160-64.
9. The Board of Trustees will, if feasible, return or destroy all your Protected Health Information, in whatever form or medium (including any electronic medium under the Board of Trustees custody or control), received from the Plan, including all copies of any data or compilations derived from and allowing identification of any Participant who is the subject of the Protected Health Information, when your Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all your Protected Health Information, the Board of Trustees will limit the use or disclosure of any of your Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Authorization

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

Definitions

Business Associate means a person or entity who provides certain functions, activities or services to the I.B.E.W. / NECA Sound and Communications Health and Welfare Plan involving the use and/or disclosure of Protected Health Information.

Protected Health Information means individually identifiable health information that is transmitted or maintained by electronic media or is transmitted or maintained in any other form.
DEFINITION OF TERMS

**Accidental Bodily Injury** – Physical damage to an individual which, independent of all other causes, is evidenced by a visible contusion or wound on the exterior of the body, except in the case of drowning or internal injuries revealed by autopsy.

**AD&D Insurance** – Accidental Death and Dismemberment insurance under the Group Policy.

**Beneficiary** – A person or entity named, on a form and in a manner approved by the Board of Trustees to receive benefits for loss of life and accidental death.

**Benefit Booklet** – This booklet and any amendments, additions, or deletions hereto; or subsequently made to the Plan.

**Benefit Period** – Claims incurred for services rendered January through December of a calendar year. A benefit period is established and benefit payment begins when you have incurred, during a calendar year covered charges that exceed the deductible amount. All covered charges for all illnesses incurred during a benefit period are used in computing benefit payments. A benefit period terminates on the last day of the calendar year in which it was established.

**Board of Trustees** – The individuals who govern the I.B.E.W/NECA Sound and Communications Health and Welfare Plan and their successors.

**Category 2/Subscription Agreement** – A written agreement between the Board of Trustees and a contributing employer that allows the contributing employer to provide health and welfare benefits to its employees who do not receive benefits pursuant to a collective bargaining agreement.

**Chemical Dependency** – A physical and/or psychological addictive relationship that an individual has with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis.

Chemical Dependency does not include an addiction to, or dependency on, tobacco, tobacco products or foods.

**Collective Bargaining Agreement** – A Labor Agreement between an employer and a Local Union providing for Contributions to the Trust / Plan.

**Contributing Employer** – An employer who is obligated to make health and welfare contributions to the Trust on behalf of employees pursuant to a Collective Bargaining Agreement or Category 2 Subscription Agreement.

**Contribution or Employer Contribution** – The payments required of a Participating Employer by the terms of a Collective Bargaining Agreement or Subscription Agreement for the purpose of covering Employees and their Dependents under this Plan.

**Cosmetic Surgery** – The surgical alteration of tissue for the improvement of your appearance rather than improvement or restoration of bodily function.

**Covered Charges** – Charges covered under this Plan.

**Deductible** – A set amount of covered charges which must be paid by you.

**Dependent** –

1. An employee’s spouse (if not legally separated from the employee). Coverage for the spouse ends on the date of the divorce or legal separation unless COBRA coverage is elected.

2. a. An employee’s unmarried child (including a stepchild, legally adopted child or child placed in an employee’s home pending adoption) from live birth until the end of the month the child attains age 19.

   b. An employee’s unmarried child (including a stepchild or legally adopted child or child placed in an employee’s home pending adoption) who has attained age 19 if the child is:

      (i) Mentally or physically unable to earn a living and proof of incapacity is furnished to the Board of Trustees within thirty-one (31) days of the date coverage would have ended due to age;

      (ii) Single and actually dependent on the employee for the majority of his or her support; and

      (iii) Covered by this plan just prior to the day the child attains age 19.

   c. An employee’s unmarried child (including a stepchild, legally adopted child or child placed in an employee’s home pending adoption) who is enrolled in an accredited school as a full-time student and has not attained age 25.
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3. An employee’s unmarried grandchild, niece or nephew in the custody of the employee and, for whom the employee is providing the majority of his or her support will be considered a dependent if the employee has been named as legal guardian by a court of competent jurisdiction until the end if the month the grandchild, niece or nephew attains age 19. Coverage for the grandchild, niece or nephew can continue beyond age 19 if the grandchild, niece or nephew meets the criteria in paragraph 2(b) or 2(c) above.

4. In the event that a husband and wife are both concurrently covered as employees herein,
   a. Each will also be considered a dependent of the other, and
   b. Each dependent child of such husband and wife will be considered a dependent of both husband and wife. However, no more than 100% of covered charges will be paid.

Doctor or Physician – An individual licensed and holding a degree as a Medical Doctor or Doctor of Osteopathy.

Eligibility Requirements – Conditions that an employee must satisfy to participate in the Plan and/or conditions that an employee must satisfy to obtain a benefit provided by the Plan.

Employee – A person who is working for a Contributing Employer or on the out-of-work list of an I.B.E.W. Local Union and such other non-bargaining employees of NECA employers accepted by the Board of Trustees.

Employer – Any employer with a Collective Bargaining Agreement requiring contributions to the Plan, and any employer making contributions under a written Participation/Subcription Agreement approved by the Board of Trustees.

Evidence of Good Health – Satisfactory proof, as determined by the Board of Trustees, that a person is acceptable for coverage.

Experimental or Investigational Services

1. A service is experimental or investigational for a patient's condition if any of the following statements apply to it as of the time the service is or will be provided to the patient.

The service:
   a. Cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or
   b. Is the subject of a current new drug or new devices application on file with the FDA; or
   c. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service; or
   d. Is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy as among its objectives; or
   e. Is subject to the approval or review of an Institutional Review Board ("IRB") or other body that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
   f. As to the service, the prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that (1) use of the service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity, or efficacy of the service.

2. In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon:
   a. The patient's medical records;
   b. The written protocol(s) or other document(s) pursuant to which the service has been or will be provided;
   c. Any consent document(s) the patient or patient's representative has executed or will be asked to execute, to receive the service;
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d. The files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;

e. The published authoritative medical or scientific literature regarding the service, as applied to the patient's illness or injury; and

f. Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

3. If two or more services are part of the same plan of treatment or diagnosis, all of the services are excluded if one of the services is experimental or investigational.

Fund Administrator – United Administrative Services, whose address is 1120 S. Bascom Avenue, San Jose, CA 95128-3590.

Gender and Number – When necessary to the meaning hereof, and except when otherwise indicated by the context, either the masculine or the neuter pronoun will be deemed to include the masculine, feminine and the neuter and the singular will be deemed to include the plural, however, only one benefit will apply in any one case.


Health Care Facility – A facility which is licensed by the State or which is accredited by the Joint Commission on Accreditation of Hospitals.

Hospital – A facility with:
1. License (if required) as a hospital;
2. Is open at all times;
3. Is operated mainly to diagnose and treat illnesses on an inpatient basis;
4. Has a staff of one or more doctors on call at all times;
5. Has 24-hour nursing services by Registered Nurses;
6. Is not mainly a skilled nursing facility, clinic, nursing home, rest home, convalescence home or like place; and
7. Has organized facilities for major surgery.

Hospital Discharge Planning – A service of interplan to arrange for care at home instead of hospital confinement.

Injury – An injury to your body.

Illness –
1. A disorder or disease of the body or mind;
2. An accidental bodily injury; or

All illnesses due to the same cause, or to a related cause, will be deemed one illness.

Medical Necessity – Those services and supplies required for diagnosis or treatment of an illness, injury, mental illness or chemical dependency and which, in the judgment of the Board of Trustees, are:
1. Consistent with the symptoms or diagnosis and treatment of your condition;
2. Appropriate with regard to standards of good medical practice;
3. Not primarily for the convenience of you or a provider of services or supplies;
4. Cannot be left out without adversely affecting your condition; and
5. The least costly of the alternative supplies of levels of service that can be safely provided to you. This means, for example, that care rendered in a hospital inpatient setting or by a nurse in your home is not medically necessary if it could be provided in a less expensive setting, such as skilled nursing facility without harm to you.

The fact that a provider may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply medically necessary.
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**Medicare** – Medical benefits provided by Title XVIII of the Federal Social Security Act.

**Mental Illness** – Conditions and diseases listed in the most recent edition of the Internal Classification of Diseases (ICD) as psychoses, neurotic disorders or personality diseases; other non psychotic mental disorders listed in the ICD as determined by the Board of Trustees. Mental illness does not include the treatment of Chemical Dependency.

**Month** – A period starting at 12:01 a.m. on any day in a given Calendar Month and ending at 12:01 a.m. on that same numbered day in the next Calendar Month. If that next Calendar Month does not have a same numbered day, the month will end at 11:59 p.m. of the last day of that next calendar Month (Examples: 12:01 a.m. of May 14 up to 12:01 a.m. of June 14; 12:01 a.m. of May 31 through 11:59 p.m. of June 30.)

**Necessary to the Care or Treatment of Illness** – Recommended by a Provider and commonly recognized in the Provider’s profession as proper care or treatment of your medical needs. Any final review will be based on professional medical opinion. Also, in the case of hospital or skilled nursing facility confinement, the length of confinement and the services and supplies furnished by the hospital or skilled nursing facility will be considered “medically necessary” only if it is determined by professional medical review that they are related to the care or treatment of illness. The Board of Trustees does not consider hospitalization medically necessary if the care could be adequately and safely provided in other than a hospital or inpatient setting, such as a skilled nursing facility or outpatient clinic.

The treatment, services or supplies must not be:

1. For the scholastic, education or vocational training of the patient; or
2. Experimental in nature; or
3. Primarily for the convenience of you or a provider of services or supplies.

**New Employee** – An employee who has not been eligible for coverage.

**Outpatient Service** – A program or service providing treatment by appointment. It must be licensed and approved by the Mental Health Division of the Office of Alcohol and Drug Abuse Programs.

**Owner** – An "owner" is:

1. A sole proprietor or partner if the business is not incorporated;
2. A shareholder with 10% or more of the stock if the business is incorporated; or
3. The spouse of a person described in 1 or 2 above.

Exceptions: a shareholder or the spouse of an owner may be reclassified as a bargaining unit employee by providing evidence satisfactory to both the I.B.E.W. Local Union and NECA that his/her duties are limited to bargaining unit work and that another person actively operates and controls the business.

**Palliative Care** – Care primarily for the relief and control of distressing symptoms, not a cure.


**Pregnancy** – One’s pregnancy, childbirth or related medical conditions, including complications of pregnancy.

**Preferred Provider**

Any physician, hospital, medical clinic or facility which belongs to the Preferred Provider Organization network recognized by the Plan as a Preferred Provider.

**Provider** –

1. A licensed Medical Doctor (M.D.).
3. A Chiropractic physician (D.C.) (under certain limited conditions).
4. A Doctor of Medical Dentistry (D.M.D.).
6. Denturist (under certain conditions).
7. Optometrist (O.D.).
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8. A Doctor of Podiatric Medicine (D.P.M.).

9. Licensed Clinical Psychologist (PhD).

10. Clinical Social Worker; a social worker who:
   a. Has a master’s or doctoral degree in social work;
   b. Has at least two years of clinical social work practice;
   c. Is certified by the Academy of Certified Social Workers (ACSW); and
   d. In states requiring license, certification, or registration, is licensed, certified, or registered as a social worker where the services are rendered (LCSW or RCSW).

11. Master of Science or Arts, Certified Competent Clinician Audiology

12. A Nurse Midwife, who:
   a. Is a Certified Nurse Practitioner;
   b. Is certified by the American College of Nurse Midwives;
   c. Is under the supervision of a qualified physician or hospital; and
   d. Is licensed as a Nurse Midwife by the state in which care is rendered (if that state’s laws license Midwives).

13. A registered Physical Therapist who is licensed as a Physical Therapist by the state in which care is rendered (if that state’s laws license Physical Therapists), for rehabilitative services rendered upon the written referral of a qualified physician.

14. Speech Therapist who:
   a. Has a master’s degree in speech pathology;
   b. Has completed an internship; and
   c. Is licensed by the state in which he or she performs his or her services, if that state requires licensing.

15. A legally qualified Physician’s Assistant who is certified by the National Commission on Certification of Physician’s Assistants; or is a certified graduate of an approved training course which is accredited by the American Medical Association’s Committee on Allied Health Education; and works for a clinic or for a licensed physician who is an M.D. or D.O. This does not apply if applicable law does not allow it.


Room and Board Charges – Charges made by a hospital or skilled nursing facility for the room, meals and routine nursing services for covered individuals confined as bed patients. Room and board is limited to the hospital’s prevailing charge for a semi-private room.

Self-Funded Plan or Plan – The health and welfare benefits described in this booklet.

Sickness – Your sickness, illness or disease.

Skilled Nursing Facility – A facility qualified as such under Medicare.

Special Charges – Those charges made by the hospital for other than room and board. Special charges include, but are not limited to, charges made by a legally qualified physician for professional services in connection with radiology and pathology. Anesthesiology is included unless otherwise provided under the surgical benefits.

Summary Plan Description (SPD) – A written statement of the Plan which includes a statement of eligibility, benefits provided and employee rights and appeal procedures.

Terminally Ill – The condition has reached a point where recovery can no longer be expected and you are facing imminent death.

TMJ/Temporomandibular Joint Syndrome – Pain or other symptoms affecting the head, jaw, and face that are believed to result when the temporomandibular joints (jaw joints) and the muscles and ligaments that control and support them do not work together correctly. Also referred to as Myofacial Pain Disorder.


Trust Agreement – The document entered into by the Board of Trustees of the I.B.E.W./NECA Sound and Communications Health and Welfare Plan which sets forth the provisions by which the Plan shall be governed.
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Usual, Customary and Reasonable Charges (UCR) – The usual charges made by the person, group or other entity rendering or furnishing the services, treatments or materials, but in no event charges in excess of the general level of charges made by others rendering or furnishing such services, treatments or materials to persons of similar income or net worth within the area in which you normally reside for illnesses comparable in severity and nature to the illness being treated. As to any particular services, treatments or materials, the term “area” means a county or such representative cross section of persons, groups or other entities rendering or furnishing such services, treatments or materials to persons of similar income or net worth. If you receive a covered service that costs more than this usual, customary and reasonable charge, the Plan will pay benefits based only on the amount considered usual, customary and reasonable.

You or Your – The employee and/or dependent(s).
I.B.E.W. / NECA SOUND AND COMMUNICATIONS
HEALTH AND WELFARE PLAN

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