IBEW / NECA SOUND AND COMMUNICATIONS HEALTH AND WELFARE TRUST FUND

For Benefits in Effect as of

JANUARY 1, 2013

SUMMARY PLAN DESCRIPTION

GCC/IBT 926M

IMPORTANT PLAN CONTACT INFORMATION

Plan Participant Website – www.soundcommbenefits.com

As a companion to this Summary Plan Description, the Trust Administrative Office has developed a website for the IBEW/NECA Sound and Communications Health and Welfare Plan. The website address is **www.soundcommbenefits.com**. This website is designed to be a user-friendly resource of information and important documents for Plan participants.

Throughout this Benefit Booklet, you'll find references to **www.soundcommbenefits.com** and how You can use it to understand Your health and welfare benefits and make the Plan work better for You and Your dependents. For example, the website includes free online access to:

- Online versions of benefit-related booklets and Plan highlights;
- Updates to this Benefit Booklet;
- Online versions of forms, including enrollment applications and claim forms;
- Links to service provider websites, including Kaiser Permanente and United HealthCare; and
- Personalized benefit information about You and Your current coverage, including the amount in Your Reserve Dollar Bank Account, on the secure portion of the website.

To access the secure portion of the website, log in with Your personal username and password and follow the prompts.

We hope You will access the site often and find it to be a valuable tool in Your benefits planning.

Important Plan Contact Information

Your Service Providers:		**Phone Numbers / Websites:**
Trust Administrative Office	For questions about eligibility for coverage, premiums, Reserve Dollar Bank Account or HRA, and to request Benefit Booklets:	Call the Trust Administrative Office: United Administrative Services (408) 288-4400 Toll-Free: 1-800-541-8059 or go online to: **www.soundcommbenefits.com**
Self-Funded Medical Indemnity PPO Plan and/or Self-Funded Dental Benefits	For questions about claim payment, claim forms and benefit information:	Call the Trust Administrative Office: United Administrative Services (408) 288-4400 Toll-Free: 1-800-541-8059 or go online to: **www.soundcommbenefits.com**
Anthem Blue Cross Preferred Provider Organization (PPO)	To locate a participating Preferred Provider physician, clinic, Urgent Care Center, Hospital, chiropractor, acupuncturist, or medical specialist:	Call the Trust Administrative Office: United Administrative Services (408) 288-4400 Toll-Free: 1-800-541-8059 or go online to: **www.anthem.com/ca**

Your Service Providers:		Phone Numbers / Websites:
Kaiser Permanente (HMO)	For questions about benefit information or to obtain ID Cards:	Call Kaiser Permanente: Toll-Free: 1-800-464-4000 (Refer to Group # 919) or go online to: **www.kaiserpermanente.org**
United HealthCare (HMO)	For questions about benefit information or to obtain ID Cards:	Call United HealthCare: Toll-Free: 1-800-624-8822 (Refer to Group #140167) or go online to: **www.uhc.com**
RESTAT (Pharmacy Benefit Manager)	For questions about prescription drug benefits or to locate a participating retail pharmacy:	Call RESTAT: Toll-Free: 1-800-248-1062 or go online to: **www.restat.com**
Postal Prescription Services (Mail Order Prescription Drug Provider)	For questions about mail order prescription drug benefits or to place a mail order prescription to be filled:	Call Postal Prescription Services: Toll-Free: 1-800-552-6694 or go online to: **www.ppsrx.com**
First Dental Health, Inc. (Preferred Provider Dental Organization – PPDO)	To locate a participating Preferred Provider dentist:	Call First Dental Health: Toll-Free: 1-800-334-7244 or go online to: **www.firstdentalhealth.com**
Optum Health	For questions about mental health, substance abuse and member assistance program benefits:	Call Optum Health: Toll-Free: 1-877-225-2267
Vision Service Plan (VSP)	For questions about vision benefits, vision claims or to locate a participating VSP Provider:	Call Vision Service Plan (VSP): Toll-Free: 1-877-877-7195 or go online to: **www.vsp.com**

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INTRODUCTION

The Board of Trustees is pleased to issue this new Benefit Booklet effective January 1, 2013. This Benefit Booklet serves as the Plan Document for the IBEW / NECA Sound and Communications Health and Welfare Trust Fund (referred to as “the Plan” in this booklet).

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

- Eligibility to participate in the Plan;
- The circumstances that may result in termination of eligibility to participate in the Plan;
- The benefits provided by the Plan;
- Appeal rights if Your claim is denied; and
- Your rights under the Employee Retirement Income Security Act of 1974 (ERISA) and multiple other Federal laws as listed in the Table of Contents.

The Board of Trustees has three medical plans available to You and Your Dependents. You and Your Dependents can have Medical Benefits provided by Kaiser Permanente, United HealthCare or the Self-Funded Medical Indemnity PPO Plan benefits described in this Benefit Booklet. The Board of Trustees offers dental benefits to You and Your Dependents by Plan benefits described in this Benefit Booklet. You and Your Dependents will be provided with the vision benefits described in this Benefit Booklet.

Regardless of the medical plan You choose, You and Your Dependents are eligible for the member assistance benefits described in this Benefit Booklet. The Employee is also eligible for short-term disability benefits (Category 1 – bargaining unit Employees only), life insurance benefits and accidental death and dismemberment benefits described in this Benefit Booklet.

The benefits provided by the Trust are not vested. Although the Board of Trustees intends to continue to provide health and welfare benefits for You and Your Dependents, unforeseen circumstances may make it inadvisable to continue the Self-Funded Medical Indemnity PPO Plan, United HealthCare Plan and Kaiser Permanente Plan in their present form. The Board of Trustees reserves the right to amend, change or terminate the Self-Funded Medical Indemnity PPO Plan, United HealthCare Plan and Kaiser Permanente Plan. The Trustees reserve the right to change the eligibility rules, change or reduce benefits and require or increase self-payments. All benefits are subject to future amendments adopted by the Board of Trustees increasing or decreasing benefits.

The Board of Trustees has discretionary authority to interpret all provisions of this Benefit Booklet and determine all factual issues (resolve factual disputes) including, but not limited to, eligibility to participate, eligibility for benefits and the amount of benefits, if any, to be paid. No individual Trustee, Union Representative, Employer Representative or employee of the Trust Administrative Office is authorized to interpret this Benefit Booklet for the Board of Trustees. The Board of Trustees has authorized employees of the Trust Administrative Office to respond informally to You or Your Dependent's written or oral inquiries on an informal basis. However, the written and oral answers are not binding upon the Board of Trustees.

Terms and phrases that have initial capital letters are defined terms. See the Definition of Terms section starting on page 128.

If You would like further information or assistance, please call or write the **Trust Administrative Office**:

UNITED ADMINISTRATIVE SERVICES

Mailing Address
P.O. Box 5057
San Jose, CA 95150-5057

Street Address
1120 S. Bascom Ave.
San Jose, CA 95128-3590

Phone Number:	(408) 288-4400
Toll Free Number:	1-800-541-8059
Fax Number:	(408) 288-4419
Business Hours:	9:00 am to 4:30 pm Monday through Friday
Email:	infos&c@uastpa.com

ELIGIBILITY AND ENROLLMENT PROCEDURES

Eligibility for Category 1 (Bargaining Unit) Employees

A Category 1 (bargaining unit) Employee works under a Collective Bargaining Agreement between an Employer and certain Local Unions of the I.B.E.W. (6, 100, 180, 234, 302, 332, 340, 551, 591, 595, 617 or 684). Employers who have a Collective Bargaining Agreement with any of these 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 an Employee performs. All hours, for the purpose of calculating Contributions, will be treated as straight-time hours.

All Employer Contributions paid to the Trust are credited (in dollars) to Your Reserve Dollar Bank Account. You may call the Trust Administrative Office or go to the Trust's website at **www.soundcommbenefits.com** to view Your current and future eligibility.

To become eligible for health and welfare coverage and to maintain health and welfare coverage, You must have sufficient money in Your Reserve Dollar Bank Account in any qualifying month to meet the required charge for coverage in the corresponding coverage month, as shown in the table below.

Sufficient Money in Your Reserve Dollar Bank Account in the Qualifying Month of…	Provides Coverage for the Corresponding Month of…
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February
January	March
February	April
March	May
April	June

Partial Self-Payments

If You are a Category 1 (bargaining unit) Employee, You may maintain coverage by making timely self-payments in the amount equal to the required monthly charge less the existing dollar credit in Your Reserve Dollar Bank Account. You must make the required self-payment by the 10th day of the month for which You are self-paying the premium. For example, a partial self-payment for April coverage must be made by April 10. You must meet the requirements of rule 1, 2, 3, or 4 (as outlined on page 4) to make a partial self-payment.

To make a partial self-payment 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 self-payment to continue coverage, You will not be eligible to make future partial self-payments until Your Reserve Dollar Bank Account has enough money to pay for a month of coverage, except as set forth under the COBRA Continuation Coverage rules starting on page 16.

Requirements to Make a Partial Self-Payment or Use Your Reserve Dollar Bank Account

To be eligible to make a partial self-payment or use Your Reserve Dollar Bank Account, You must meet one of the following:

1. Working for a Contributing Employer in a bargaining unit position or in a non-bargaining unit position provided the Contributing Employer is a party to a Category 2 (Subscription) Agreement;

2. Available for immediate dispatch to a Contributing Employer by being registered on the appropriate local union's out-of-work list;

3. Working for a Contributing Employer that contributes to another welfare benefit plan that is a party to a reciprocity agreement with the Trust; 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 of the above paragraphs for twelve (12) consecutive months, at the end of the 12th month, Your Reserve Dollar Bank Account will be forfeited and the funds will be transferred to the general assets of the Trust.

If You Are Out of Work

As long as You have sufficient money in Your Reserve Dollar Bank Account and comply with paragraphs 1, 2, 3, or 4 above, Your benefits will be continued.

If You do not have sufficient money in Your Reserve Dollar Bank Account and return to work and accumulate the required amount in Your Reserve Dollar Bank Account, Your benefits will be automatically reinstated as of the first day of the coverage month corresponding to the qualifying month as previously described in the table on page 3.

Utilization or Freezing of Your Reserve Dollar Bank Account

Upon leaving covered employment a participant having a Reserve Dollar Bank balance under this Plan will have the option of:

1. Running out his / her Reserve Dollar Bank Account; or

2. Serving written notice to the Board of Trustees subsequent to leaving covered employment of his / her desire to freeze his / her Reserve Dollar Bank Account for a period not to exceed twelve (12) months. This time limit will not apply to participants who enter active duty in the Uniformed Services of the United States.

   a. This option is for the primary purpose of avoiding duplicate primary coverage of the participant which would result in unnecessary utilization of the Reserve Dollar Bank Account while primary coverage through another I.B.E.W. health and welfare plan exists. However, there are other purposes for which the Board of Trustees may allow, in its discretion, freezing the Reserve Dollar Bank Account as stated in this provision.

   b. This option is available to a participant upon leaving covered employment that becomes a participant in another I.B.E.W. health and welfare plan, enters active duty in the Uniformed Services of the United States, or has made application for COBRA coverage and is eligible for COBRA subsidy assistance under the American Recovery and Reinvestment Act of 2009 as an Assistance Eligible Individual (AEI).

c. The freezing of Your Reserve Dollar Bank Account will become effective on the first day of the calendar month beginning subsequent to the date of serving said notice, provided said notice is received by the Trust Administrative Office prior to the 25th of the month. If received after the 25th of the month, the freezing will become effective on the first day of the second following calendar month.

d. Upon reentry into covered employment within the 12-month period from date of serving of the above notice, You are allowed thirty (30) days within which to file notice of Your intention to unfreeze Your Reserve Dollar Bank Account.

e. It is further provided that Your unfrozen Reserve Dollar Bank Account shall be reassigned effective the first day of the second month after You have returned to covered employment or are available for immediate employment under coverage of this Plan. Reserve Dollar Bank Accounts amounting to less than the required amount for one month of coverage may not be frozen. To the extent the provisions of this section conflict with any provision of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), USERRA shall control.

If You Move From One Contributing Employer to Another

Your benefits will continue, provided You maintain the necessary money in Your Reserve Dollar Bank Account as of the first of each month. If You transfer from one Contributing Employer to another, Your Reserve Dollar Bank Account will be maintained, and You will not lose any coverage. You should make sure Your new Employer is contributing to the Trust for You.

The Maximum Accumulation in Your Reserve Dollar Bank Account

The maximum amount You are allowed to accumulate in Your Reserve Dollar Bank Account is set by the Board of Trustees. You should check with the Trust Administrative Office for the maximum amount.

To check on Your Reserve Dollar Bank Account, contact the Trust Administrative Office. (Contact information can be found on page 2 of this Benefit Booklet).

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 COBRA continuation coverage. See page 16 of this Benefit Booklet.

Eligibility for Category 2 (Non-Bargaining) Employees

An Employer required to contribute to the Trust for Category 1 (bargaining unit) Employees may execute a Category 2 (Subscription) Agreement that allows coverage for non-bargaining Employees subject to the following rules:

1. The Employer must have a Collective Bargaining Agreement with I.B.E.W. Local No. 6, 100, 180, 234, 302, 332, 340, 551, 591, 595, 617 or 684 (the Trust Local Unions) that requires the Employer to make a Contribution to the Trust for Category 1 (bargaining unit) Employees;

2. The Employer must employ at least one Category 1 (bargaining unit) Employee covered by the Ninth District Northern California Sound and Communications Collective Bargaining Agreement for no less than seven calendar months per year or 1,260 hours per year to be eligible for a Category 2

(Subscription) Agreement. Should the Employer fail to do so, the Category 2 (Subscription) Agreement will cease. There will be no right of COBRA continuation coverage for Category 2 (non-bargaining) Employees as this condition is not a "qualifying event" as defined by COBRA.

3. Employers electing to cover Category 2 (non-bargaining) Employees must cover such Employees pursuant to the following schedule:

   - Less than five (5) employees - 100% of full-time non-bargaining employees.
   - Five (5) or more employees – 80% of full-time non-bargaining employees.

4. Newly hired Category 2 (non-bargaining) Employees must be covered the first of the month following completion of ninety (90) days of continuous full-time employment by paying the applicable monthly premium (Contribution) for such coverage in advance. Category 2 (non-bargaining) Employees working eighty (80) or more hours per month or equivalent pay period are considered to be employed "full-time."

5. Contributing Employers not electing to cover their Category 2 (non-bargaining) 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 (non-bargaining) Employees. All enrollment applications and premium (Contribution) payments must be received by the Trust Administrative Office by December 15th and thereafter the monthly premium (Contribution) must be paid in advance each month to the Trust.

6. Category 2 (non-bargaining) Employees do not have a Reserve Dollar Bank Account but are eligible for all benefits under this Plan except the short-term disability benefit and the Health Reimbursement Arrangement (HRA).

7. The Trustees shall establish the monthly premium (Contribution) amount required for Category 2 (non-bargaining) participants from time to time. The monthly premium (Contribution) amount may be obtained by contacting the Trust Administrative Office.

8. Employers electing to cover their Category 2 (non-bargaining) Employees must sign a written Category 2 (Subscription) Agreement acknowledging the Plan rules and agreeing to be bound by the terms of the Trust Agreement for the IBEW / NECA Sound and Communications Health and Welfare Trust, and specifically to comply with Plan rules concerning compliance with payroll audits and assessment of liquidated damages, interest and other costs if premium (Contribution) payments are not received by the due date specified in this section of the Benefit Booklet as well as the Category 2 (Subscription) Agreement.

9. The Contributing Employer's principal place of business must be within the jurisdiction of the Ninth District Northern California Sound and Communications Collective Bargaining Agreement. "Principal place of business" shall include an address:

   a) on the contractor's license,

   b) on the contractor's license bond,

   c) to which Employees report and from which Employees travel to job sites, and

   d) at which a project manager or superintendent has a permanent office.

10. Coverage will only be provided to those Category 2 (non-bargaining) Employees that work within the geographic jurisdiction of the Ninth District Northern California Sound and Communications Collective Bargaining Agreement.

The monthly premium (Contribution) amount for Employees covered by a Category 2 (Subscription) Agreement will be determined by the Board of Trustees. For further details and complete information, contact the Trust Administrative Office for a copy of the current Category 2 (Subscription) Agreement document in use.

Dependents – Eligibility

An Employee's Dependents are defined in the Definition of Terms section of the Benefit Booklet. See pages 129 through 130.

Dependents will be eligible for health and welfare coverage on the date the Employee becomes eligible or, if later, the date the individual becomes a Dependent of the Employee. For example, a new spouse will become a Dependent on the date of marriage, a new child will become a Dependent on the date of birth, adoption, or placement in the Employee's home pending adoption, and a Domestic Partner or a Domestic Partner's children will become Dependents per the time frames detailed on page 12.

A Dependent's coverage will terminate on whichever of the following dates is applicable:

1. The first day of the month following the date he or she no longer qualifies as a Dependent; for example, divorce, legal separation, dissolution of a domestic partnership or a child who no longer meets the definition of Dependent due to age. In the case of a Domestic Partner and a Domestic Partner's children who do not qualify as Dependents of the Employee for federal income tax purposes under Section 152 of the Internal Revenue Code, coverage will terminate on the date the federal and, if applicable, state taxes are not paid to the Trust by the due date; or

2. The date the Employee's health and welfare coverage ends.

Special Enrollment Rights

Employees and Dependents have special enrollment rights in the Self-Funded Medical Indemnity PPO Plan as well as the United HealthCare Plan and the Kaiser Permanente Plan if the Employee or Dependent did not enroll when first eligible and the criteria set forth below are met.

Late Enrollees

A late enrollee is an Employee or Dependent who did not enroll in the Self-Funded Medical Indemnity PPO Plan, the United HealthCare Plan, or Kaiser Permanente Plan, when first eligible for coverage and does not qualify as a special enrollee. A late enrollee may enroll during the next open enrollment period.

Special Enrollee

A special enrollee is an Employee or Dependent that is allowed to enroll in the Self-Funded Medical Indemnity PPO Plan, the United HealthCare Plan, or Kaiser Permanente Plan after initial eligibility for coverage and before the next open enrollment period because of a loss of group health coverage, a change in family status or enrollment rights under the Children's Health Insurance Coverage Act.

Special Enrollees Who Have Lost Other Group Health Coverage

If the Employee did not enroll himself/herself or a Dependent for Trust coverage because other group health coverage was in effect, the Employee may enroll himself/herself or a Dependent for Trust coverage within thirty (30) days after the other group health coverage ends, so long as the following conditions are met:

1. The person to be enrolled was covered under another group health plan at the time Trust coverage was previously offered;

2. a. COBRA continuation coverage under another group health plan was exhausted. Failure to pay the premium or premature termination of COBRA continuation coverage does not satisfy this requirement; or

   b. Coverage under another group health plan was terminated as the result of loss of eligibility for reasons such as legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment (failure to pay the premium does not satisfy this requirement); or

   c. Employer Contributions toward the premium for other group health coverage was terminated; and

3. The person must request Trust coverage not later than thirty (30) days after the date the other group health coverage ends. Contact the Trust Administrative Office for enrollment information or go to **www.soundcommbenefits.com**.

Coverage under the Self-Funded Medical Indemnity PPO Plan, the United HealthCare Plan, or Kaiser Permanente Plan will become effective on the first day of the month following the Trust Administrative Office's receipt of the enrollment form and payment of the required premium. If the Trust Administrative Office does not receive the enrollment form within thirty (30) days after the date the other group health coverage ended, You will be considered a late enrollee.

Special Enrollees Who Have a Change in Family Status

Individuals who previously declined enrollment in the Self-Funded Medical Indemnity PPO Plan, the United HealthCare Plan, or Kaiser Permanente Plan and have a change in family status may be eligible to enroll as a special enrollee. Marriage, establishment of a domestic partnership, adoption, placement for adoption, or birth of a child is considered a change in family status. You must request enrollment for the newly acquired Dependent within thirty (30) days of the marriage, creation of the domestic partnership, adoption, placement for adoption, or birth of a child. In the event of marriage or creation of a domestic partnership, coverage will become effective on the day of the event. In the case of the birth of a child, coverage will become effective on the date of birth. In the case of adoption or placement for adoption, coverage will become effective on the date of the adoption or placement for adoption. If the Trust Administrative Office does not receive the enrollment form within thirty (30) days of the date of the change in family status, You will be considered a late enrollee. Contact the Trust Administrative Office for the enrollment form.

Special Enrollment Rights under the Children's Health Insurance Coverage Act

An Employee or Dependent who is eligible to enroll for Trust coverage but did not enroll under either of the following circumstances will have special enrollment rights.

1. The Employee or Dependent is covered under Medicare or a state's Children's Health Insurance Program and coverage for the Employee or Dependent is terminated as a result of a loss of eligibility for such coverage; or

2. The Employee or Dependent becomes eligible for a premium assistance subsidy from Medicare or a state's Children's Health Insurance Program to help pay the cost of Trust coverage.

If either of these circumstances occurs, the Employee or Dependent will have a sixty (60) -day period to enroll for Trust coverage. If the Trust Administrative Office does not receive the enrollment form within sixty (60) days after loss of coverage or the date of eligibility for premium assistance, You will be considered a late enrollee. Contact the Trust Administrative Office for the enrollment form.

Family and Medical Leave

If You are a Category 1 (bargaining unit) or Category 2 (non-bargaining) Employee and leave work temporarily for Family and Medical Leave, the Trust will pay up to three months of health and welfare coverage for You (or up to six months of health and welfare coverage for You if the Family and Medical Leave is to care for a covered servicemember) if You meet certain criteria. If You qualify, You receive the same coverage You had before taking Family and Medical Leave.

Prerequisites for Coverage under Family and Medical Leave

1. You must be actively employed by a Contributing Employer at the time You take Family and Medical Leave;

2. You must have worked for one or more Contributing Employers for at least twelve (12) months (not consecutive) before the Family and Medical Leave;

3. You must have worked for one or more Contributing Employers at least 1,250 hours during the twelve (12) months before the Family and Medical Leave;

4. The Family and Medical Leave must be for one of the following reasons:

   a. Birth of a child or placement of a child for adoption or foster care;

   b. To care for a spouse, child or parent with a "serious health condition";

   c. Your own "serious health condition";

   d. To care for a spouse, child, parent, or next of kin who is a covered servicemember who is undergoing medical treatment, recuperation, or therapy; who is in out-patient status; or is on a temporary disability list for a serious Injury or Illness; or

   e. To deal with a qualifying exigency (urgent, pressing need or emergency) arising because a spouse, child, or parent is on active duty or has been called to active duty in the armed forces.

5. A "serious health condition" is an Illness, Injury or impairment involving:

   a. Inpatient treatment;

   b. Absence from work or school for three (3) or more days with continuing treatment by a health care Provider;

   c. 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

   d. Prenatal care.

6. You must intend to return to work for Your Employer after the Family and Medical Leave; and

7. You may use the Family and Medical Leave benefit once per twelve (12) consecutive months.

The Family and Medical Leave Benefit

If You qualify for the Family and Medical Leave benefit as a Category 1 (bargaining unit) Employee, Your Reserve Dollar Bank Account will be frozen at the end of the month that You leave work for the Family and Medical Leave. If You qualify for the Family and Medical Leave benefit as a Category 2 (non-bargaining)

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 will pay for up to three months of health and welfare coverage (or up to six months of health and welfare coverage if the Family and Medical Leave is to care for a covered servicemember). After three or six months of Trust paid coverage, You are responsible for payment of health and welfare coverage out of Your Reserve Dollar Bank Account or by COBRA payment.

Application Process

If You think You qualify for Family and Medical Leave and want to use this benefit, call the Trust Administrative Office to obtain an application form. You need to complete the application form and return it to the Trust Administrative Office. You will be notified whether You qualify for this benefit.

Trust paid health and welfare coverage will stop before the third month or sixth month if You return to work or otherwise terminate Your Family and Medical Leave.

Military Service

If You or a Dependent join the Armed Forces of the United States or are called to active duty for more than thirty (30) days, health and welfare coverage for You or Your Dependent will end on the date You or Your Dependent enters full-time active duty.

The Federal Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provides certain rights that include:

1. Your Reserve Dollar Bank Account will be preserved for a maximum of five years. However, You may use Your Reserve Dollar Bank Account to provide coverage for Your Dependents.

2. There will be COBRA-type continuation coverage rights for Your Dependents to extend health and welfare coverage for a maximum of 24 months from the date military leave began. See the COBRA section on page 16 or contact the Trust Administrative Office for more information. This right applies only to Dependents covered by the Plan at the time of military service.

3. When Your military leave is expected to last thirty-one (31) days or less, Your Employer may be required to pay the health and welfare coverage for this limited period of time. You must notify Your Employer of the expected military leave and must return to employment within the time frames established by USERRA.

4. When Your military service ends, any eligibility waiting period cannot be applied to You and Your Dependents unless the waiting period was established after You left for military service and the new waiting period applies to all Employees. When returning from military service, You cannot be required to satisfy any Preexisting Condition exclusion unless the Preexisting Condition exclusion applies to all Employees. This rule does not apply to service related Injuries or Illnesses.

If You have questions concerning Your rights under USERRA, contact Your Employer or the Trust Administrative Office.

Reciprocal Agreements

The IBEW / 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 IBEW / NECA Sound and Communications Health and Welfare Plan to Your home fund or from the health and welfare fund where You are working to the IBEW / NECA Sound and Communications Health and Welfare Plan, contact the Trust Administrative Office for instructions.

An election to transfer Your Contributions to another health and welfare fund will act as a release and waiver of any and all claims against the IBEW / NECA Sound and Communications Health and Welfare Plan once Contributions have been transferred and receipted by the health and welfare 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 IBEW / 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 IBEW / NECA Sound and Communications Health and Welfare Plan. By electing transfer, You waive any claims that might otherwise be made based on the retention by the IBEW / 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.

You will be required to register in the Electronic Reciprocity Transfer System (ERTS) before health and welfare Contributions can be transferred.

Notification of Change of Address

From time to time, the Trust Administrative Office 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 Trust Administrative Office 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 Trust Administrative Office in a timely manner.

DOMESTIC PARTNER COVERAGE, RULES AND PROCEDURES

The Trust's three medical plan options (Self-Funded Medical Indemnity PPO Plan, Kaiser Permanente Plan and United HealthCare Plan) offer health and welfare coverage to an Employee's Domestic Partner and the Domestic Partner's Dependent children under the laws of the State of California subject to the rules set forth below, in other sections of this Benefit Booklet and in the Kaiser Permanente and United HealthCare booklets.

See the Definition of Terms section of the Benefit Booklet on page 130 for the definition of "Domestic Partner".

A Certificate of Registration of a Domestic Partnership issued by the State of California must be provided to the Trust Administrative Office in order for your Domestic Partner to be eligible for coverage under the Plan. You can learn more about how to obtain a Certificate and who qualifies as a Domestic Partner under the laws of the State of California by visiting the State of California's Domestic Partners Registry at **www.sos.ca.gov/dpregistry.**

You will also be required to complete an Affidavit and Declaration of Domestic Partnership document provided to you by the Plan. The document requires both signatures and must be notarized. Contact the Trust Administrative Office for the document.

An Employee may enroll a Domestic Partner and the Domestic Partner's Dependent children for health and welfare coverage during the following time periods:

1. Within thirty (30) days after the Employee becomes eligible for Employer paid health and welfare coverage;
2. Within thirty (30) days after the Domestic Partnership relationship is established;
3. Within thirty (30) days after the Domestic Partner has a new child (enrollment for the child only if the Domestic Partner is already enrolled for coverage);
4. During Special Enrollment Rights periods described starting on page 7; and
5. During the open enrollment period established by the Board of Trustees.

Contact the Trust Administrative Office for enrollment forms or go to **www.soundcommbenefits.com**.

If an Employee enrolls a Domestic Partner and a Domestic Partner's Dependent child for health and welfare coverage and allows the health and welfare coverage for the Domestic Partner and a Domestic Partner's Dependent child to lapse (for example does not pay the federal and, if applicable, state taxes) while health and welfare coverage is maintained for the Employee, the Employee will not be allowed to re-enroll his/her Domestic Partner and Domestic Partner's Dependent child for health and welfare coverage until the next open enrollment period unless there is an enrollment right under the Special Enrollment Rights section starting on page 7.

Tax Consequences of Domestic Partnership Coverage

Federal law requires that the value of Employer paid health and welfare coverage provided to a Domestic Partner and the Domestic Partner's Dependent children are taxable income to the Employee unless the Employee certifies that the Domestic Partner and/or the Domestic Partner's Dependent children are claimed as "dependents" of the Employee for federal income tax purposes under 26 U.S.C. § 152 of the Internal Revenue Code. An Employee who elects to provide health and welfare coverage for a Domestic Partner and the Domestic Partner's Dependent children as a result of Employer paid health and welfare coverage, absent a certification of dependent status satisfactory to the Board of Trustees, will be required to pay the federal and, if applicable, state income taxes associated with the value of Employer paid health and welfare coverage for the Domestic Partner and the Domestic Partner's Dependent children by the date established

by the Board of Trustees or the coverage for the Domestic Partner and the Domestic Partner's children will terminate. The Board of Trustees determine the value of the health and welfare coverage for the Domestic Partner and, if applicable, the Domestic Partner's Dependent children. Contact the Trust Administrative Office for the current information. The Employee will receive a W-2 form from the Trust Administrative Office at the end of each year in an amount equal to the value of the Employer-paid health and welfare coverage provided to the Domestic Partner and, if applicable, the Domestic Partner's Dependent children.

A payment to the Trust to cover the federal taxes must be paid by the 5th day of the month preceding the coverage month. For example, payment of federal taxes must be made by June 5th in order for Your Domestic Partner to have July health and welfare coverage. If the Employee fails to make a timely payment, health and welfare coverage for the Domestic Partner and, if applicable, the Domestic Partner's Dependent children will end and the Employee will not be allowed to re-enroll the Domestic Partner and, if applicable, the Domestic Partner's Dependent children until the next open enrollment period unless there is an enrollment right under the Special Enrollment Rights section starting on page 7.

If an Employee elects to provide health and welfare coverage for a Domestic Partner and, if applicable, the Domestic Partner's Dependent children, and certifies that the Domestic Partner and/or Dependent children are claimed as "dependents" of the Employee for federal income tax purposes under 26 U.S.C. § 152 of the Internal Revenue Code, the Employee will not receive a W-2 form from the Trust for the value of the Employer paid health and welfare coverage and will not be subject to the pre-payment of federal taxes detailed in the preceding paragraph. In order to avoid receipt of a W-2 form and the pre-payment of federal taxes, the Employee must sign a certificate regarding "dependent" status of the Domestic Partner and, if applicable, the Domestic Partner's children prior to the first month in which health and welfare coverage is provided to the Domestic Partner and, if applicable, the Domestic Partner's Dependent children and before January 1 of each subsequent year. Contact the Trust Administrative Office to obtain the certification form.

If a Domestic Partner has health and welfare coverage through the Self-Funded Medical Indemnity PPO Plan and his/her own health and welfare coverage, the benefits provided by the Self-Funded Medical Indemnity PPO Plan will be secondary with respect to payment of the Domestic Partner's health and welfare claims. If the Domestic Partner has health and welfare coverage through the Self-Funded Medical Indemnity PPO Plan and his/her own health and welfare coverage and the Domestic Partner has Dependent children that the Employee does not claim as "dependents" on his/her federal income tax return, the Self-Funded Medical Indemnity PPO Plan will be secondary with respect to payment of the Dependent children's health and welfare claims.

BOTH THE EMPLOYEE AND DOMESTIC PARTNER HAVE AN OBLIGATION TO NOTIFY THE TRUST ADMINISTRATIVE OFFICE IN WRITING WITHIN THIRTY (30) DAYS AFTER THEY NO LONGER QUALIFY AS DOMESTIC PARTNERS. THE ADDRESS OF THE TRUST ADMINISTRATIVE OFFICE IS:

United Administrative Services

Mailing Address	*Street Address*
P.O. Box 5057	1120 S. Bascom Ave.
San Jose, CA 95150-5057	San Jose, CA 95128-3590

If either the Employee or Domestic Partner makes a false statement or representation regarding their status as Domestic Partners in the enrollment form or fails to notify the Trust Administrative Office in writing within thirty (30) days after they no longer qualify as Domestic Partners and the Trust suffers any loss as a result thereof, the Trust or the Board of Trustees may bring a civil action against either or both the Employee and the Domestic Partner to recover any losses incurred by the Trust including reasonable attorney's fees and court costs. The Board of Trustees may also offset prospective benefits payable to either the Employee, Domestic Partner or either of their Dependent children in order to recover the Trust's loss. The Board of Trustees may also withdraw money from the Employee's Reserve Dollar Bank Account in order to recover the Trust's loss.

PLAN OPTIONS

An Employee participating in the Trust has the option of enrolling in one of three medical and prescription drug plans: the Self-Funded Medical Indemnity PPO Plan described in this Benefit Booklet, United HealthCare Plan (HMO) or Kaiser Permanente Plan (HMO). The United HealthCare Plan and the Kaiser Permanente Plan are available only for Employees who reside in certain geographic areas. Check with the Trust Administrative Office for the geographic areas served by United HealthCare Plan or the Kaiser Permanente Plan.

What Is the Difference Between an HMO and a PPO?

Traditional HMO plans (United HealthCare Plan and Kaiser Permanente Plan) generally pay 100% of the cost of care after a copayment, but require You to use in-HMO network Providers (i.e., a Physician, Clinic or Hospital), and have Your care coordinated through Your Primary Care Physician. Except in the case of emergencies, coverage is not provided for non-HMO network Providers or for services not authorized by the HMO plan.

Traditional PPO plans (Self-Funded Medical Indemnity PPO Plan) generally pay a percentage of the cost of care after a Deductible; the remaining amount is paid by You. The services of Preferred (in-network) Providers are paid at a higher percentage than the services of Non-Preferred (out-of-network) Providers. Generally PPO plans offer more flexibility on Provider choice and services.

If You meet the eligibility requirements for coverage, You may choose to enroll Yourself and Your Dependents for medical, prescription drug, dental, vision and member assistance benefits. Only Employees are eligible for short-term disability benefits (Category 1 – bargaining unit Employees only), life insurance and accidental death and dismemberment coverage.

You may change Your medical and prescription drug coverage provider choice during the open enrollment period. For example, You can switch from the United HealthCare Plan or Kaiser Permanente Plan to the Self-Funded Medical Indemnity PPO Plan or from the Self-Funded Medical Indemnity PPO Plan to United HealthCare Plan or Kaiser Permanente Plan. The annual open enrollment period is determined and announced by the Board of Trustees.

If You are considering the United HealthCare Plan or Kaiser Permanente Plan, You should refer to the benefit book offered by United HealthCare or Kaiser Permanente for the schedule of benefits, limitations, exclusions and the claim appeal procedures. Contact the Trust Administrative Office for a Benefit Booklet. (Contact information can be found on page 2 of this Benefit Booklet.)

Self-Funded Medical Indemnity PPO Plan

If You select the Self-Funded Medical Indemnity PPO Plan, the following benefits are described in this Benefit Booklet:

- Medical;
- Prescription drug;
- Dental;
- Vision;
- Member assistance;
- Life insurance
- Accidental death and dismemberment; and
- Short-term disability.

United HealthCare Plan

If You select the United HealthCare Plan, Your medical and prescription drug benefits are described in a separate Benefit Booklet prepared by United HealthCare. Your dental, vision, member assistance, accidental death and dismemberment, life insurance and short-term disability benefits are described in this Benefit Booklet.

Kaiser Permanente Plan

If You select the Kaiser Permanente Plan, Your medical and prescription drug benefits are described in a separate Benefit Booklet prepared by Kaiser Permanente. Your dental, vision, member assistance, accidental death and dismemberment, life insurance and short-term disability benefits are described in this Benefit Booklet.

COBRA CONTINUATION COVERAGE

This section is applicable to all Employees and their Dependents regardless of whether You are enrolled in the Self-Funded Medical Indemnity PPO Plan, United HealthCare Plan or Kaiser Permanente Plan.

Introduction

This section 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. COBRA continuation coverage can become available to You and Your Dependents who are covered under this Plan or an insured plan (United HealthCare Plan or Kaiser Permanente Plan) when You or Your Dependents would otherwise lose Your group health and welfare 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.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health and welfare coverage that would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this section. 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 health and welfare coverage because of a qualifying event. Depending on the type of qualifying event, Employees, spouses and Dependent children 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.

If You are an Employee, You will become a qualified beneficiary if You will lose Your coverage under the Self-Funded Medical Indemnity PPO Plan or an insured plan (United HealthCare Plan or Kaiser Permanente Plan) because either of the following qualifying events happens:

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 lose Your coverage under the Self-Funded Medical Indemnity PPO Plan or an insured plan (United HealthCare Plan or Kaiser Permanente Plan) 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 enrolled in 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 Trust Administrative Office within sixty (60) days after the divorce or legal separation and can establish that the Employee canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA continuation coverage may be available for the period after the divorce or legal separation.

Dependent children will become qualified beneficiaries if they lose coverage under the Self-Funded Medical Indemnity PPO Plan or an insured plan (United HealthCare Plan or Kaiser Permanente Plan) because any of the following qualifying events happen:

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 enrolled in 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." See definition of “Dependent” on pages 129 through 130.

Special Second Election Period

Certain Employees and former Employees who are eligible for federal trade adjustment assistance or alternative trade adjustment assistance are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of sixty (60) days or less (but only if the election is made within six (6) months after coverage under the Self-Funded Medical Indemnity PPO Plan or an insured plan (United HealthCare Plan or Kaiser Permanente Plan) is lost). If You are an Employee or former Employee and You qualify for federal trade adjustment assistance or alternative trade adjustment assistance, contact the Trust Administrative Office after qualifying for federal trade assistance or alternative trade adjustment assistance or You will lose any right that You may have to elect COBRA during a special second election period. Contact the Trust Administrative Office for more information about this special second election period.

Notices and Elections of COBRA Continuation Coverage

Under the Self-Funded Medical Indemnity PPO Plan and an insured plan (United HealthCare Plan or Kaiser Permanente Plan), Your spouse's coverage ends the last day of the month that a divorce or legal separation occurs and 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, legal separation, or a Dependent child who no longer qualifies as a Dependent child), You, the spouse or Dependent child must notify the Trust Administrative Office **in writing** within sixty (60) days after the divorce, legal separation, or child losing Dependent status using the procedures specified under the heading “Notice Procedures.” If the notice is not provided in writing to the Trust Administrative Office 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 Trust Administrative Office:

United Administrative Services

Mailing Address	*Street Address*
P.O. Box 5057	1120 S. Bascom Ave.
San Jose, CA 95150-5057	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 Trust name (IBEW / NECA Sound and Communications Health and Welfare Trust Fund), the name and address of the Employee covered by the Trust and the name(s) and address(es) of the qualified beneficiary(ies) who will lose coverage due to a qualifying event. The notice must also state the qualifying event (divorce, legal separation, or a 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 Trust Administrative Office receives timely written notice that one of the three qualifying events (divorce, legal separation, or child losing Dependent status) has happened, the Trust Administrative Office will notify the family member of the right to elect COBRA continuation coverage. You, Your spouse or Dependent child will also be notified of the right to elect COBRA continuation coverage automatically (without any action required by You, Your spouse or Dependent child) when coverage is lost because Your employment ends, hours of employment are reduced, You die or become enrolled in Medicare (Part A, Part B or both).

You, Your spouse or Dependent child 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 Trust Administrative Office. Each qualified beneficiary has a right to elect COBRA continuation coverage. **If You, Your spouse or Your Dependent child does not elect COBRA continuation coverage within the sixty (60) -day election period, the qualified beneficiary(ies) will lose the right to elect COBRA continuation coverage. The election to accept COBRA continuation coverage is effective on the date the election is mailed to the Trust Administrative Office.** A qualified beneficiary may change a prior rejection of COBRA continuation coverage at any time until the election period expires.

When considering whether to elect COBRA, You should take into account that a failure to elect COBRA will affect Your future rights under federal law. First, You can lose the right to avoid having Preexisting Condition exclusions apply 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 may help You avoid such a gap. Second, You will lose the guaranteed right to purchase individual health insurance policies that do not impose Preexisting Condition exclusions if You do not get COBRA continuation coverage for the maximum time available to You. Finally, You should take into account that You have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which You are otherwise eligible (such as a plan sponsored by Your spouse's employer) within thirty (30) days after Your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if You get COBRA coverage for the maximum time available.

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 such as short-term disability 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. All family members must select the same coverage.

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, legal separation or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the Employee's termination of employment or reduction of the Employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are several ways in which this 18 months of COBRA continuation coverage can be extended.

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 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee can last until 36 months after the date of Medicare entitlement. For example, if an Employee became entitled to Medicare eight months before the date his or her coverage terminates because of a reduction of hours of employment, COBRA continuation coverage for his or her spouse and Dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 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 up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-Month period of COBRA continuation coverage

If You or a qualified beneficiary covered under the Self-Funded Medical Indemnity PPO Plan or an insured plan (United HealthCare Plan or Kaiser Permanente Plan) is determined by the Social Security Administration to be disabled and You notify the Trust Administrative Office in a timely fashion, You and Your Dependents may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability must have to have started at a time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must make sure that the Trust Administrative Office is notified **in writing** of the Social Security Administration's disability determination within sixty (60) days after the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must follow the procedures under the heading "Notice Procedures" on page 18. In addition, Your written notice must include the name of the disabled person, the date that he or she became disabled, the date that the Social Security Administration made its determination and 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 TRUST ADMINISTRATIVE OFFICE WITHIN THE REQUIRED TIME, 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 Trust Administrative Office in writing within thirty (30) days after the Social Security Administration's determination.

Second qualifying event extension of 18-Month period of COBRA continuation coverage

If Your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. Notice of the second qualifying event must be given in a timely manner to the Trust Administrative Office. 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 (Part A, Part B, or both), 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 the Self-Funded Medical Indemnity PPO Plan or an insured plan (United HealthCare Plan or Kaiser Permanente Plan) had the first qualifying event not occurred. In all these cases, the spouse or Dependent child must make sure that the Trust Administrative Office 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 under the heading "Notice Procedures" on page 18. 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 TRUST ADMINISTRATIVE OFFICE 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 COBRA Continuation Coverage Costs

A qualified beneficiary who elects COBRA continuation coverage will be required to pay the cost of COBRA continuation coverage. The cost may not exceed 102% (or, in the case of an extension of COBRA continuation coverage due to a disability, 150%) of the cost to the group health Plan for coverage of a similarly situated Employee or Dependent who is not receiving COBRA continuation coverage.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance. Under the Trade Act of 2002, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health coverage, including COBRA continuation coverage. If You have questions about the Trade Act of 2002, 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.

When and How Payment for COBRA Continuation Coverage Must 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 no 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 no later than 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 the Self-Funded Medical Indemnity PPO Plan or an insured plan (United HealthCare Plan or Kaiser Permanente Plan) would have otherwise terminated up to the time You make the first payment. You are responsible for making sure that the first payment is enough to cover the entire cost. You may contact the Trust Administrative Office to confirm the correct amount of Your first payment.

Your first payment for COBRA continuation coverage should be sent to the Trust Administrative Office:

United Administrative Services

Mailing Address	*Street Address*
P.O. Box 5057	1120 S. Bascom Ave.
San Jose, CA 95150-5057	San Jose, CA 95128-3590

Monthly payments for COBRA continuation coverage

After You make Your first payment for COBRA continuation coverage, You are required to pay for COBRA continuation coverage for each subsequent month of coverage. The 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 will continue for that coverage period without any break. The Trust Administrative Office will not send notices of payments due for these coverage periods.

Monthly payments for COBRA continuation coverage should be sent to the Trust Administrative Office:

United Administrative Services

Mailing Address	*Street Address*
P.O. Box 5057	1120 S. Bascom Ave.
San Jose, CA 95150-5057	San Jose, CA 95128-3590

Grace period for monthly payments

Although monthly payments are due by the first day of the month, You have 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. 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 the Self-Funded Medical Indemnity PPO Plan or an insured plan (United HealthCare Plan or Kaiser Permanente Plan) 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 fail 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 and Dependent children will automatically end (even before the end of the maximum coverage period) if:

1. The premium is not paid by the end of the grace period;

2. After electing COBRA continuation coverage, You, Your spouse or Dependent child becomes enrolled in Medicare benefits (Part A, Part B or both);

3. After electing COBRA continuation coverage, You, Your spouse or Dependent child becomes covered under another group health plan (but only after any exclusions in the other plan for a Preexisting Condition has been exhausted or satisfied);
4. The Trust no longer provides group health coverage for any of its participants;

5. Your last Employer stops contributing to the Trust and makes a group health plan available for its Employees formerly covered under the Trust. In this situation, the group health plan maintained by

Your last Employer has the obligation to make COBRA continuation coverage available to any qualified beneficiary who was receiving COBRA coverage under the Trust on the day before the cessation of Contributions by the Employer and whose last employment prior to the qualifying event was with the Employer; or

6. During a disability extension period (explained on page 19), the disabled person is determined by the Social Security Administration to no longer be disabled. In this circumstance, COBRA continuation coverage will be terminated for any qualified beneficiary who is receiving extended COBRA continuation coverage under the disability extension as of the later of (i) the first day of the month that is more than thirty (30) days after the final determination by the Social Security Administration that You, Your spouse or Dependent child is no longer disabled; or (ii) the end of the coverage period that applies without regard to the disability extension.

You, Your spouse and/or Dependent child must notify the Trust Administrative Office in writing within thirty (30) days if, after electing COBRA continuation coverage, You, Your spouse or Your Dependent child becomes entitled to Medicare (Part A, Part B or both), becomes covered under another group health plan, or You, Your spouse or Dependent child is determined by the Social Security Administration to no longer be disabled. Follow the "Notice Procedures" on page 18.

Automatic COBRA Continuation Coverage for Your Spouse and Dependent Children in Certain Circumstances

When You elect COBRA continuation coverage, coverage for Your spouse (if he/she had coverage immediately before the qualifying event) and Your Dependent children will continue automatically unless Your spouse (if he/she had coverage immediately before the qualifying event) independently declines COBRA continuation coverage. If You choose not to elect COBRA continuation coverage, Your spouse (if he/she had coverage immediately before the qualifying event) and Dependent children may still elect COBRA continuation coverage. Of course, in all circumstances, anyone electing COBRA continuation coverage must pay the required premium.

COBRA Subsidy Due to a Terminal Illness

If Your eligibility for group health and welfare benefits terminates as a result of depletion of Your Reserve Dollar Bank Account and You elect COBRA continuation coverage, the Plan will provide up to three (3) months of COBRA Continuation Coverage if You meet the following conditions:

1. You have a Terminal Illness and death is expected within twelve (12) months;

2. Your illness has been certified by a licensed Medical Doctor (MD);

3. You have had contributions to the Health and Welfare Plan for at least 60 of the 120 months immediately preceding COBRA eligibility; and

4. The subsidy will be available only once for any Participant.

Transfer Rights

If You are covered by the United HealthCare Plan or Kaiser Permanente Plan that covers a limited geographic area and relocate to another area where Employers contributing to the Trust have an active workforce, You may be entitled to elect coverage available to other Employees working in that area. If You find Yourself in this situation, call or write the Trust Administrative Office. Under no circumstance 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 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 a qualified beneficiary provided the Employee has elected COBRA continuation coverage. The child's COBRA continuation coverage begins when the child is born and it lasts as long as COBRA continuation coverage lasts for other family members of the Employee. To be enrolled in the Self-Funded Medical Indemnity PPO Plan or an insured plan (United HealthCare Plan or Kaiser Permanente Plan), the child must satisfy the otherwise applicable eligibility requirements (for example, age).

Alternate recipients under Qualified Medical Child Support Orders

A child of an Employee who is receiving benefits under the Self-Funded Medical Indemnity PPO Plan or an insured plan (United HealthCare Plan or Kaiser Permanente Plan) pursuant to a Qualified Medical Child Support Order is entitled to the same rights under COBRA as a Dependent child of the Employee, regardless of whether that child would otherwise be considered a Dependent.

More Information about COBRA Continuation Coverage

Questions concerning the Self-Funded Medical Indemnity PPO Plan or an insured plan (United HealthCare Plan or Kaiser Permanente Plan) or Your COBRA continuation coverage rights should be addressed to the Trust Administrative Office. 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 US Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA offices are available through the website.

Keep the Trust Administrative Office Informed of Address Changes

In order to protect Your family's rights, You should keep the Trust Administrative Office informed of any changes in the addresses of family members. You should keep a copy of any notices You send to the Trust Administrative Office.

PORTABILITY HEALTH INSURANCE PLANS

This section of the Benefit Booklet applies only if You reside in California and Your medical and prescription drug benefits are provided by the United HealthCare Plan or Kaiser Permanente Plan.

California law requires some insurance companies and HMO's that previously offered You, Your spouse or Domestic Partner, and Your Dependent children group health insurance benefits to provide a choice of two health insurance plans when group health insurance coverage ends. These individual plans do not contain Preexisting Condition provisions, exclusions or waiting periods. These individual plans can be used in lieu of COBRA, during COBRA or after Your COBRA coverage has expired. The health insurance plans are called "portability health benefit plans" and are intended to improve the availability and affordability of health benefits when individuals leave group coverage.

Eligibility Requirements for Portability Health Benefit Plans

To enroll in one of the portability plans, You, Your spouse or Domestic Partner, or Dependent child must:

1. Have ended coverage or lost eligibility under the United HealthCare Plan or Kaiser Permanente Plan.

2. Have been continuously enrolled with United HealthCare Plan or Kaiser Permanente Plan, or United HealthCare Plan or Kaiser Permanente Plan and one or more other California group health plans (including any continuation coverage under COBRA) for at least one hundred eighty (180) days prior to the loss of coverage under the United HealthCare Plan and/or Kaiser Permanente Plan.

3. Be a resident of California.

4. Not be eligible for Medicare.

How to Apply for a Portability Health Benefit Plan

In order to exercise the right to enroll in one of the portability health benefit plans, You, Your spouse or Domestic Partner or Dependent child must:

1. Submit a written application to United HealthCare Plan or Kaiser Permanente Plan.

2. Apply for individual coverage within sixty (60) days after You lose Your group health insurance coverage or after Your COBRA coverage expires.

3. Be responsible for paying the cost of the individual insurance coverage.

If eligible, You have the choice of two portability health benefit plans:

1. A prevailing cost plan, which includes benefit coverage and premiums that are prevalent in the California group health insurance/United HealthCare Plan and/or Kaiser Permanente Plan marketplace; and

2. A low cost plan, which emphasizes affordability.

If You would like more information about the portability health benefit plans, contact the United HealthCare Plan or the Kaiser Permanente Plan directly.

MEDICAL BENEFITS

SELF-FUNDED MEDICAL INDEMNITY PPO PLAN

Deductible

Deductible – Employee or Dependent	$100 per calendar year
Deductible – Family	$300 per calendar year

The Deductible is the amount You must pay out of Your own pocket for Covered Charges each calendar year before the Plan begins to pay benefits. The Deductible applies to many but not all Covered Charges.

A maximum of three times the individual Deductible, no more than $100 of which may be satisfied by only one person, will be applied to the Covered Charges incurred by a family unit during a calendar year.

Once You satisfy the calendar year Deductible, the Plan pays a percentage of the Covered Charges that are subject to the calendar year Deductible noted in the Coinsurance Benefit Percentages section below.

If a single accident causes Injuries to two or more members of a family, only one Deductible will apply to the family for Covered Charges incurred during that calendar year and resulting from such Injuries. In no event will a lesser amount be paid than would be payable if this single Deductible did not apply.

Deductible Carry Over

Any amount that You pay toward Your Deductible in the fourth quarter of a calendar year (between October 1 and December 31) is credited for the current year and will be applied toward Your next year's Deductible as well.

Coinsurance Benefit Percentages

The Medical Benefits portion of this Benefit Booklet provides that all Covered Charges (other than for dental, orthodontia and vision), after satisfying the Deductible, will be payable at 80% of the Usual, Customary and Reasonable Charge for a Non-Preferred Provider and 80% or 90% of the negotiated Covered Charge for a Preferred Provider, depending upon the Covered Charge.

Preferred Provider Percentage (in PPO network)	80% or 90% of negotiated Covered Charges, depending upon the Covered Charge
Non-Preferred Provider Percentage (not in PPO network)	80% of Usual, Customary and Reasonable Charges

Determination of Benefits

Benefits to be paid will be determined by multiplying the benefit percentage by the amount of Usual, Customary and Reasonable Charges or negotiated Covered Charges in the case of a Preferred Provider in a Benefit Period that exceeds the Deductible. For example:

Hospital Visit You Are Charged	Covered Charges	You Pay Deductible	Plan Pays 90% Preferred Provider 80% Non-Preferred Provider	You Pay
$4,000	$4,000	$100	$3,900 x 90% = $3,510	$390
			$3,900 x 80% = $3,120	$780

Balance Billing

Balance billing occurs when a health care Provider bills You for charges – other than copayments, Coinsurance or any amounts that may remain on Your annual Deductible – which exceed the Plan's reimbursement for a Covered Charge. The Plan's Preferred Providers are contractually prohibited from balance billing You, but balance billing by Non-Preferred Providers is common.

What You Should Know When Visiting a Preferred Health Care Provider

Benefits paid to a Preferred Provider for covered charges are based on a negotiated discounted rate. A Preferred Provider should never balance bill You for charges that exceed that Negotiated Rate. However, Preferred Providers should bill You for the following amounts that are to be paid by You, not the Plan:

- The Coinsurance percentage, which is 10% or 20% of Covered Charges (depending on the Covered Charge), up to the annual Out-Of-Pocket Maximum
- Any amount that may remain on Your annual Deductible
- The full cost of any charges that are not covered by the Plan

When You receive a bill from Your Preferred Provider, You should compare it to the Explanation of Benefits (EOB) that You receive from the Trust Administrative Office. You will see the amount of the full charge billed and the Preferred Provider network discount deducted from the full charge. This discount is a result of a contract with the Preferred Provider Organization (PPO) network, and it should not be passed on as a charge to You. However, the Deductible and Coinsurance amounts, as well as charges for any non-covered services, are due to the Provider.

In rare cases, a Preferred Provider may mistakenly balance bill You for the amount included in the Preferred Provider network discount. If this happens, do not pay the portion of the bill that represents the Preferred Provider network discount. Also call the Trust Administrative Office at (408) 288-4400 or toll-free at 1-800-541-8059, and they will notify the Preferred Provider network to contact the Provider to correct the error.

What You Should Know When Visiting a Non-Preferred Health Care Provider

While the Plan's Preferred Provider network protects You from balance billing, You are obligated to pay whatever a Non-Preferred Provider network Provider bills You. The amounts charged by Non-Preferred Providers can vary significantly, as there are no contractual limits to what they can charge. If You plan to use a Non-Preferred Provider, it is prudent to inquire about the fees You can expect to be charged before services are rendered. However, if You receive services without prior knowledge of a Non-Preferred Provider's fees and You feel that the charges are excessive, it is within Your rights to contact the Provider to discuss the bill. Even though Non-Preferred Providers are not contractually or otherwise obligated to do so, some are willing to adjust the charges and/or work out payment plans with their patients.

How You Can Avoid Balance Billing

Choose health care Providers within the Plan's Preferred Provider network whenever possible. Preferred Provider network health care Providers are contractually prohibited from balance billing You. Refer to the Preferred Provider Organization section of this Benefit Booklet on page 33 for directions on how to find a Preferred Provider.

Out-of-Pocket Maximum

Your Out-Of-Pocket Maximum, excluding the Deductible, is $2,500 per person or $5,000 per family during a calendar year for services received from a PPO-network Preferred Provider. After the Out-Of-Pocket Maximum has been met, all Covered Charges for Medical Benefits (other than those for dental, orthodontia and vision) will be paid at 100% of the Negotiated Rate for a Preferred Provider for the remainder of the calendar year, up to the annual benefit maximum. **There is no calendar-year Out-Of-Pocket Maximum for Non-Preferred Provider Services.**

Maximum Benefit

Annual Benefit Maximum

The maximum amount of money payable to or on behalf of You for Essential Health Benefits during a calendar year is as follows:

1. Calendar Year 2013 – $2,000,000
2. Calendar Year 2014 and later – No limit.

The maximum amount of money payable to or on behalf of You for non-essential health benefits is as described in the Benefit Booklet for a particular benefit or, if there is not a specific limitation, a Two Million Dollar ($2,000,000) maximum of all aggregate Covered Charges paid.

Benefit Period

A Benefit Period begins in a calendar year when You have incurred Covered Charges that 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 applied to the Deductible amount.

A Benefit Period 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.

Covered Charges

A Covered Charge must be Medically Necessary in order to be eligible for payment. The Plan will pay 80% of negotiated Covered Charges from a Preferred Provider and 80% of Usual, Customary and Reasonable Charges from a Non-Preferred Provider unless otherwise noted in the schedule of covered charges below.

1. Semi-private room and board and routine nursing for confinement in a Hospital **(Preferred Provider covered at 90%).**
2. Semi-private room and board and routine nursing for confinement in a Skilled Nursing Facility (not to exceed the average semi-private Hospital room rate). Services must commence within fourteen (14) days after discharge 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 **(Preferred Provider covered at 90%)**;

   b. For those Hospitals that make a combined charge for room and board and intensive nursing care, the 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 **(Preferred Provider covered at 90%)**.

4. Medical services and supplies furnished by the Hospital.

5. Anesthetics and their administration.

6. Outpatient surgery in a Hospital or ambulatory surgery center **(Preferred Provider covered at 90%)**.

7. Medical treatment given by or at the direction of a Doctor, if such treatment is administered by a Provider.

8. Services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN) 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 that is necessary because of an Illness (other than a functional nervous disorder), or is necessary because of surgery on account of an Illness. Charges by a Doctor or speech therapist for speech therapy that is necessary as the result of Down Syndrome. If the speech therapy is necessary because of a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

11. X-rays (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 performed within 24 months of an Accidental Bodily Injury.

14. Ambulance services as follows:

    a. Ground vehicle transportation by a licensed professional ambulance service to the nearest appropriate health care facility as Medically Necessary for treatment of a medical Emergency, acute Illness or inter-health care facility transfer; and

    b. Air transportation to the nearest appropriate health care facility, only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to Your health status.

15. Medical supplies as follows:

    a. Drugs that 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 so long as the loss did not occur within the 6 months immediately prior to coverage under the Plan unless the artificial limb or eye is requested within 12 months after coverage began under the Plan;

d. Lens, each eye, immediately following and because of cataract surgery;

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 24 months of ownership, but only so long as dialysis treatment continues to be Medically Necessary. Also covered are charges for supplies, materials and repairs necessary for the proper operation of such equipment and also reasonable and necessary expenses for the training of a person to operate and maintain the equipment for Your personal and exclusive use. No benefits are paid on or after the day You are entitled to benefits under Medicare;

g. Rental of hospital-type medical equipment up to purchase price for other than kidney dialysis, including wheelchair, hospital bed, equipment for the treatment of respiratory paralysis and equipment for the use of oxygen;

h. Purchase of Durable Medical Equipment (hospital-type medical equipment). If approved, payment will be prorated over 12 months beginning with date of purchase;

i. Prosthesis; and

j. Surgically implantable contraceptive devices, intrauterine devices (IUDs), diaphragms, Depo-Provera and other non-self administered contraceptives.

16. Preventive Care Benefits

Preventive care benefits are provided under three categories: annual women's examinations, well baby care, and physical examinations. A description of each follows:

a. Annual Women's Examinations

Annual women's breast, pelvic, and Pap smear examinations are covered once every calendar year. However, more frequent examinations will be covered if Medically Necessary and recommended by the woman's health care Provider. Except for Pap smears and mammograms, which are paid according to this Annual Women's Examinations benefit, any covered expenses for laboratory and x-ray procedures that accompany the examination will be covered according to the Diagnostic X-Rays and Laboratory Services provision. Note that routine mammographic breast screening will be covered according to the following schedule:

- Age 35 to 40, one mammogram in that period; and
- Age 40 and above, one mammogram per calendar year.

More frequent mammograms will be covered if Medically Necessary and recommended by the woman's health care Provider.

b. Well Baby Care

The Plan covers charges of the professional Provider for physical examinations of Your eligible Dependent child(ren) less than four (4) years of age, including the standard in-Hospital examination at birth and diagnostic x-ray and laboratory services. **Well Baby Care charges received from Non-Preferred Provider Hospitals are not covered.**

The Plan will cover up to eight (8) visits for physical examinations and immunizations for Your eligible Dependent child(ren) through the first 36 months of life. Routine immunizations are covered at one hundred percent (100%) and routine Outpatient physical examinations or

diagnostic testing is covered at eighty percent (80%) of Usual, Customary and Reasonable Charges. There is no Deductible for covered well baby care expenses.

c. Physical Examinations

For You and Your eligible Dependent over four years of age, the Plan covers 100% of the cost of physical examinations and related laboratory test work associated with the exam including EKG, lung function test, chest x-ray, blood test for cholesterol, blood sugar, liver and kidney function, as long as a third party is not liable for these charges and You use Preferred Provider. A maximum benefit of $400 per person per calendar year. No Deductible applies. **No benefit is paid for services received from Non-Preferred Providers.** The Plan only covers as often and up to the following amounts:

Frequency:

Children: Age 4 to 6, one examination every calendar year.
Age 7 to 18, one examination every two calendar years

Adults: Age 19 to 34, one examination every four calendar years.
Age 35 and above, one examination every two calendar years.

Amounts Payable: For each physical examination, including related laboratory tests and x-ray examinations, the Plan pays up to $400. Any excess charges do not count toward the Plan's annual Out-Of-Pocket Maximum.

17. Immunizations for general use for both adults and children. For participants over age 18, the Plan covers only those immunizations recommended by the American Academy of Family Physicians. Immunizations for hepatitis B are covered only for Your eligible Dependent children under age 19. Covered Charges do not include immunizations for the sole purpose of travel, occupation, or residence in a foreign country.

18. Maternity Care Expenses (Employee and Spouses Only) as follows:

Maternity care expenses are covered the same as any other Illness and are provided only to You or Your spouse for maternity care, childbirth and treatment of related conditions. Coverage must be in effect at the time of delivery. Hospital well baby nursery charges are covered only in a Preferred Provider-contracted Hospital and only during the mother's normal maternity stay.

Benefits are not available for maternity-related expenses for Your pregnant child, even if Your child is covered under the Plan.

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).

19. Chiropractic and Acupuncture Treatment: Charges for treatment are limited to a maximum of twenty (20) visits per calendar year. Payments are subject to the Plan's Deductible and Coinsurance. Maximum radiological X-ray charges for chiropractic services are limited to $100 per calendar year.

20. Formula and related supplies if the formula is supplying 100% of the individual's nutritional intake; for example, the individual must be fed through a tube.

21. Bariatric surgical procedures including gastric-bypass and laparoscopic procedures but only if surgery is preapproved in writing by a medical review agency selected by the Board of Trustees using its most stringent Medical Necessity review criteria.

22. Diabetes Management Training, which is supervised by a physician, which includes nutritional counseling, glucose testing, medications, and insulin injections.

23. Temporomandibular Joint Syndrome (TMJ): Charges for necessary care and treatment of Temporomandibular Joint Syndrome and associated myofacial pain are limited to a maximum benefit payment of $3,000 lifetime Outpatient care and $10,000 lifetime for surgeons' charges for surgical care. Hospital charges associated with surgical care are payable as any other Illness.

24. Services of a Doctor or an occupational therapist for rehabilitation services provided to restore fully developed skills that were lost or impaired due to an Injury, Illness or sickness.

25. The following human organ or tissue transplants that are non-investigational:

    a. Joint replacements;

    b. Human kidney transplants;

    c. Human artery or vein transplants;

    d. Human heart valve replacements;

    e. Prosthetic bypass or replacement vessels;

    f. Human bone marrow transplants, peripheral stem transplantation or umbilical cord transplants;

    g. Cornea transplants; and

    h. Implantable prosthetic lenses in connection with cataracts.

    The following transplant or replacement of organ or tissue procedures are subject 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 transplants:

    i. Human liver transplants ;

    j. Human pancreas transplants;

    k. Human heart transplants;

    l. Human heart and lung transplants; and

    m. Human lung transplants – single or double.

    All transplant procedures must be Preauthorized by Anthem Blue Cross for type of transplant and be Medically Necessary. Preauthorization requirements are a part of the benefit administration of the Trust and are not a treatment recommendation. The actual course of medical treatment the participant chooses remains strictly a matter between the participant and his or her physician.

Live Donors

If the transplant involves a living donor, covered donor costs are as follows:

- If an eligible Participant receives a transplant and a donor is also covered under this Plan, payment for the recipient and the donor will be made under each individual's coverage.

- If the donor is not covered under this Plan, benefits will be limited by any payment which might be made under any other hospitalization coverage plan.

- If the participant is the donor and the recipient is not covered under this Plan, benefits will be limited by any payment which might be made by the recipient's hospitalization coverage with another company. No payment will be made under this Plan for the recipient.

General Provisions and Definitions for Human Organ or Tissue Transplants

"Covered donor costs" means all costs, direct and indirect (including administration costs) incurred in connection with medical services required to remove the organ or tissue from either the donor's or the self-donor's body; preserving it; and transporting it to the site where the transplant is performed.

Benefits for antirejection drugs are payable under the Prescription Drug Benefits of the Plan.

Covered services include certain services and supplies not otherwise excluded in this Summary Plan Description Benefit Booklet and rendered in association with a covered transplant, including pre-transplant procedures such as organ harvesting (donor costs), post-operative care (including antirejection drug treatment) and transplant-related chemotherapy.

PREFERRED PROVIDER ORGANIZATION

As part of the Trust's voluntary Preferred Provider Organization (PPO) program, You can qualify for substantial savings on a wide variety of health care services offered by the Trust's Preferred Provider network. When You choose a Provider or facility who is member of the Preferred Provider network, Covered Charges paid by the Trust are usually higher and You pay less out of pocket. This is because Providers and facilities of the Preferred Provider network have contracted to provide services at Negotiated Rates. In addition, bills from Providers and facilities who are members of the Preferred Provider network are paid at 80% or 90% (depending on the Covered Charge) of the Negotiated Rate after the Deductible has been satisfied rather than 80% of the Usual, Customary and Reasonable Charge after the Deductible has been satisfied for a Non-Preferred Provider. **Of special note, there is no calendar year Out-Of-Pocket Maximum for Non-Preferred Provider Services.**

Retaining Your Freedom of Choice

The Preferred Provider network is voluntary and presents no limitations to You. You are free to choose any health care Provider or facility You wish, even if that Provider, Physician, Hospital or clinic is not a member of the Preferred Provider network.

The Trust Preferred Provider (PPO) Network – Anthem Blue Cross

The Anthem Blue Cross Preferred Provider network is available throughout California.

Anytime You need to see a Provider or need to be admitted to a Hospital or clinic in California consult the Anthem Blue Cross PPO Network Directory for a list of Providers, Physicians, Hospitals and clinics that are members of the Anthem Blue Cross Preferred Provider network. You can review the list of Preferred Providers, Hospitals, and clinics by telephoning the Trust Administrative Office at (408) 288-4400 or toll-free at 1-800-541-8059 or by using the Anthem Blue Cross website. If You use the Anthem Blue Cross website, follow these directions:

1. Go to www.anthem.com/ca
2. Under USEFUL TOOLS, select "*Find a Doctor.*"
3. In the first step, select the type of services You are looking for: Doctors, Hospitals, urgent care, etc.
4. Second, You can narrow Your search based on Provider type, specialty, facility, location, gender of Doctor, etc.
5. Third, enter Your zip code to find services in Your area.
6. Finally, in step 4, click on the button labeled *"I have an insurance card; use the first 3 letters of my member ID,"* then enter the first three letters of Your member identification card and click "*Search.*"
7. Clicking on a Doctor's name will provide You with basic information about the Doctor such as medical school attended and languages spoken.

How to Get the Most Out of the Preferred Provider (PPO) Network.

The following are a few helpful hints when using the Anthem Blue Cross Preferred Provider network:

1. When You seek medical services, identify Yourself as a member of the Anthem Blue Cross Preferred Provider network and present Your identification card.

2. If Your Doctor is not a member of the Preferred Provider network, You can still save money by asking Your Doctor to refer You to a Preferred Provider network Hospital, clinic, or specialist.

Additional Provider Discounts

The Trust has an arrangement with organizations that attempt to obtain discounts for Your medical bills even if the Provider, Hospital, or clinic is not a member of the Preferred Provider network. For example, assume You have met Your Deductible for the year and saw a Non-Preferred Provider who charged $500. Under normal circumstances, You would pay 20% of the bill ($100) and the Trust would pay 80% of the bill ($400). On occasion, the Trust may be able to obtain a discount from the Non-Preferred Provider who would, for example, agree to accept $400 in full payment of the charge. Under this scenario, You would pay 20% of the bill ($80) and the Trust would pay 80% of the bill ($320).

UTILIZATION REVIEW PROGRAM, PERSONAL CASE MANAGEMENT SERVICES, AND DISEASE MANAGEMENT PROGRAM

Utilization Review Program

Utilization Review is a program that reviews the Medical Necessity and quality of Inpatient stays for hospitalization, Substance Abuse and Mental Illness. This program is provided by Anthem Blue Cross for medically-related hospitalization and by Optum Health for Substance Abuse and Mental Illness hospitalization.

The Utilization Review program evaluates the Medical Necessity and appropriateness of care and the setting in which care is provided. You and Your Provider (physician) are advised if Anthem Blue Cross or Optum Health have determined that services can be safely provided in an Outpatient setting, or if an Inpatient stay is recommended. Services that are Medically Necessary and appropriate are certified by Anthem Blue Cross or Optum Health and monitored so that You know when it is no longer Medically Necessary and appropriate to continue those services.

It is Your responsibility to see that Your Provider (physician) starts the Utilization Review process before scheduling You or Your eligible Dependents for any service subject to the Utilization Review program.

Utilization Reviews are conducted for the following services:

- All Inpatient Hospital stays and residential treatment center admissions;
- Facility-based care for the treatment of mental or nervous disorders and Substance Abuse;
- Organ and tissue transplants;
- Infusion therapy;
- Admissions to a Skilled Nursing Facility; and
- Select imaging procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging. You may call the Trust Administrative Office to find out if an imaging procedure requires pre-service review.

Authorization given by Anthem Blue Cross for an Inpatient stay for hospitalization, or by Optum Health for an Inpatient stay for Substance Abuse or Mental Illness, is only for the purpose of reviewing whether the admission is necessary for the care and treatment of an Illness or Injury. It does not guarantee that all charges are covered by the Plan. All charges submitted for payment are subject to all terms and conditions of the Plan, regardless if preadmission authorization is received from Anthem Blue Cross or Optum Health.

You and Your Doctor have the final decision regarding hospitalization and medical treatment.

Contacting Anthem Blue Cross or Optum Health for Utilization Review

For all Inpatient Hospital stays, except childbirth, You, a family member, Your Doctor or Hospital should contact Anthem Blue Cross toll-free at 1-800-274-7767 prior to admission. For all Inpatient stays for the treatment of Substance Abuse or Mental Health, You, a family member, Your Doctor or Hospital should contact Optum Health toll-free at 1-877-225-2267 prior to admission.

The information You will need to provide to Anthem Blue Cross or Optum Health is as follows:

1. Trust Name: **IBEW / NECA Sound and Communications Health and Welfare Trust Fund**;
2. Employee's name and identification number (usually the last 4 digits of Your Social Security Number);
3. Name, date of birth and address of person being admitted;
4. Family contact and telephone numbers;
5. Admitting Doctor's name and telephone number;
6. Hospital name, address and telephone number;
7. Date of admission; and
8. Diagnosis, surgery or procedure to be performed.

Pre-Service Review

Anthem Blue Cross provides a pre-service review and evaluation for each Inpatient hospitalization, except childbirth, and Optum Health provides a pre-service review and evaluation for all Inpatient stays for the treatment of Substance Abuse and Mental Illness.

1. **Non-Emergency Hospitalization and Inpatient Stay for Medically-Related Conditions or for the Treatment of Substance Abuse and/or Mental Illness**

   Before admission to a Hospital as an Inpatient for any reason except childbirth and before an Inpatient stay for the treatment of Substance Abuse and/or Mental Illness, You, a family member, Your Doctor or Hospital must call Anthem Blue Cross or Optum Health at least ten (10) days prior to the scheduled hospitalization or Inpatient stay to determine whether the Hospital stay is Medically Necessary.

2. **Urgent Hospitalization and Inpatient Stay for Medically-Related Conditions or for the Treatment of Substance Abuse and/or Mental Illness**
   An urgent hospitalization or Inpatient stay for the treatment of Substance Abuse and/or Mental Illness occurs when the condition is not life threatening but requires an admission of less than ten (10) days notice. In this situation, You, a family member, Your Doctor or Hospital should notify Anthem Blue Cross or Optum Health prior to the scheduled hospitalization or Inpatient stay. If You, a family member, Your Doctor or Hospital do not have time to call Anthem Blue Cross or Optum Health before admission, You, a family member, Your Doctor or Hospital should call Anthem Blue Cross or Optum Health within 48 hours of the admission.

3. **Emergency Hospitalization and Inpatient Stay for Medically-Related Conditions or for the Treatment of Substance Abuse and/or Mental Illness**

   An emergency Hospital admission or Inpatient stay for the treatment of Substance Abuse and/or Mental Illness occurs as the result of an unforeseen condition requiring immediate medical attention and does not require preadmission certification. However, Anthem Blue Cross or Optum Health should be called by You, a family member, Your Doctor or Hospital within 48 hours of the admission.

Concurrent Review

After admission to a Hospital or Inpatient stay for the treatment of Substance Abuse and/or Mental Illness,

Anthem Blue Cross or Optum Health will continue to evaluate Your progress through concurrent review that monitors the length of stay. If Anthem Blue Cross or Optum Health disagrees with the length of stay recommended by Your Doctor, or determines the continued confinement is no longer necessary, You and Your Doctor will be consulted. You and Your Doctor have the final decision regarding Hospital confinement and medical treatment.

Retrospective Review

Retrospective review is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

Hospital Discharge Planning

During Your Hospital stay or Inpatient stay for treatment of Substance Abuse and/or Mental Illness, Anthem Blue Cross or Optum Health will monitor Your progress. Timely discharge planning will help You return home at the earliest date.

Personal Case Management Services

The Trust offers personal case management services through Anthem Blue Cross for medically-related conditions. When You need intensive, chronic or expensive care, Anthem Blue Cross health care professionals guide You through the complex health care system. Anthem Blue Cross nurses work with You, Your family and Your Doctor to help find appropriate Providers, and determine the right care and equipment for Your specific needs. They:

- Support You and Your Doctor in Your plan of care and help You avoid delays or complications;
- Provide support and education if You or a family member is living with diabetes, heart disease or respiratory disease;
- Help You evaluate clinical, economic and humanistic outcomes; and
- Encourage You to take an active role in Your health care.

Personal case management services are voluntary. If You call Anthem Blue Cross to Preauthorize services under the Utilization Review program, or if You have a number of claims that indicate You will need extensive or chronic care, the Trust will refer You to Anthem Blue Cross. If Anthem Blue Cross agrees that You could benefit from personal case management, an Anthem Blue Cross representative will contact You and ask You if You want the assistance of an Anthem Blue Cross health care professional.

If You, the case manager and the Trust Administrative Office agree on care not covered by the Plan that can reasonably be expected to offer a cost effective result without a sacrifice to the quality of Your care, the Board of Trustees has the right to allow the care even though the care is not covered by the Plan.

Disease Management Program

Anthem Blue Cross provides a voluntary disease management program for You and Your Dependents afflicted with coronary heart disease, congestive heart failure, asthma, diabetes and chronic obstructive pulmonary disease.

The purposes of the Disease Management Program include:

- Early detection and management of the diseases identified above;
- Encourage the patient to take an active role in the management of his/her medical condition;
- Provide education about the medical condition; and
- Encourage the patient to follow through with his/her treatment plan.

The Disease Management Program is voluntary. If You have been diagnosed with one of the diseases identified above, You may receive a brochure from Anthem Blue Cross concerning Your specific disease and a telephone call concerning how the Disease Management Program can benefit You.

SUPPLEMENTAL ACCIDENT BENEFIT

This section of the Benefit Booklet applies only to Participants enrolled in the Self-Funded Medical Indemnity PPO Plan. Participants enrolled in the United HealthCare Plan or the Kaiser Permanente Plan are not eligible for this benefit.

The Supplemental Accident benefit supplements the Medical Benefits provided by the Self-Funded Medical Indemnity PPO Plan and, therefore, are not subject to the Deductible. If a charge covered under this benefit is a covered expense under the Plan, the Supplemental Accident benefit will pay its benefit first. Such a charge will not be a covered expense under the Medical Benefits of the Plan to that extent. Covered expenses not fully reimbursed under the Supplemental Accident benefit become covered expenses under the Medical Benefits of the Plan.

The maximum benefit per accident is $500. Non-Preferred Provider expenses will be based upon Usual, Customary and Reasonable Charges.

The Plan will pay benefits for the following expenses when provided by a Preferred or Non-Preferred Provider to You or Your eligible Dependents for accidental Injuries:

1. Services and supplies (including room and board) furnished by a Hospital for medical care in that Hospital;

2. Physician's services for surgical procedures and other medical care;

3. X-ray and laboratory services;

4. Private duty professional nursing services by a registered nurse (RN), other than a nurse who ordinarily resides in the same household with the covered person or who is related by blood marriage or legal adoption to such covered person;

5. Prescription drugs and medicine dispensed by a licensed pharmacist;

6. Casts, splints, trusses, braces and crutches;

7. Surgical dressings; and

8. Ambulance service for local travel.

The accidental Injuries must be sustained while You or Your eligible Dependents are covered under the Plan and the services and supplies must be ordered by a physician and furnished within a ninety (90) day period beginning with the date the covered person sustained those Injuries.

The benefit payable is the amount of the charges actually made to the covered person for the services and supplies, but not more than the maximum Supplemental Accident Benefit in connection with all Injuries resulting from one accident.

The Supplemental Accident benefit is subject to charges for Medical and Prescription Drug benefits that are not covered by the Plan (See pages 51 through 53.) However, the limitation in reference to teeth does not apply to treatment of accidental Injury to natural teeth (including replacement of such teeth).

MENTAL HEALTH BENEFITS

Mental Health benefits are available if You are covered under the Self-Funded Medical Indemnity PPO Plan or the United HealthCare Plan. Kaiser Permanente Plan members receive Mental Health benefits from Kaiser Permanente.

Mental Health benefits are provided through a contract with Optum Health.

Schedule of Benefits

SELF-FUNDED MEDICAL INDEMNITY PPO PLAN MEMBER BENEFITS		
	In-Network	**Out-Of-Network**
Calendar Year Deductible	$100 per person, up to $300 per family	$100 per person, up to $300 per family
Calendar-Year Out-of-Pocket Maximum	$2,500 per person, up to $5,000 per family	No Out-Of-Pocket Maximum. You are responsible for 20% of ALL expenses.
Mental / Behavioral Health Inpatient Services	Plan pays 90% of Optum Health's negotiated rates after calendar-year Deductible is applied. Unlimited days based on Medical Necessity.	Plan pays 80% of Usual, Customary and Reasonable Charges after calendar-year Deductible is applied. Unlimited days based on Medical Necessity.
Mental / Behavioral Health Outpatient Services	Plan pays 80% of Optum Health's negotiated rates after calendar-year Deductible is applied. Unlimited days based on Medical Necessity.	Plan pays 80% of Usual, Customary and Reasonable Charges after calendar-year Deductible is applied. Unlimited visits based on Medical Necessity.

UNITED HEALTHCARE PLAN MEMBER BENEFITS		
	In-Network	**Out-Of-Network**
Calendar Year Deductible	None	None
Calendar-Year Out-of-Pocket Maximum	$2,000 per person, up to $6,000 per family	No Out-Of-Pocket Maximum. You are responsible for 20% of ALL expenses.
Mental / Behavioral Health Inpatient Services	Plan pays 100% after You pay $250 copay. Unlimited days based on Medical Necessity.	Plan pays 80% of Usual, Customary and Reasonable Charges after calendar-year Deductible is applied. Unlimited days based on Medical Necessity.
Mental / Behavioral Health Outpatient Services	$5 copay per visit. Unlimited visits, based on Medical Necessity.	Plan pays 80% of Usual, Customary and Reasonable Charges after calendar-year Deductible is applied. Unlimited visits based on Medical Necessity.

How to Use the Program

Preauthorization is required for all Mental Health benefits. You must obtain prior authorization through Optum Health. You may contact Optum Health 24 hours a day, 7 days a week toll-free at: 1-877-225-2267 and choose the appropriate menu prompt for assistance. The information You will need to provide Optum Health is as follows:

1. Trust Name: **IBEW / NECA Sound and Communications Health and Welfare Trust Fund**;
2. Employee's name and identification number;
3. Name, date of birth and address of person requesting benefits;
4. Identify which Trust Medical Plan option You are enrolled in: a) Self-Funded Medical Indemnity PPO Plan or b) the United HealthCare Plan;
5. Family contact and telephone numbers;
6. Doctor's name and telephone number; and
7. Diagnosis.

SUBSTANCE ABUSE BENEFITS

Substance Abuse benefits are available if You and Your eligible Dependents are covered under the Self-Funded Medical Indemnity PPO Plan or the United HealthCare Plan. Kaiser Permanente Plan members receive Substance Abuse Disorder benefits from Kaiser Permanente.

Substance Abuse benefits are provided through a contract with Optum Health.

Benefits are provided only upon the diagnosis and recommendation of an Optum Health network Physician and only for expenses for treatment recognized by the medical profession as appropriate methods of effective treatment of Substance Abuse.

"Effective Treatment of Substance Abuse" means a program of Substance Abuse therapy that meets all of the following tests:

1. It is prescribed and supervised by a Physician; and

2. The Physician certifies that a follow-up program has been established which includes therapy by a Physician, or group therapy under a Physician's direction.

Schedule of Benefits

All levels of Substance Abuse are covered under the Plan, including detoxification. You must receive services from an Optum Health approved network Provider or facility. No benefits are provided if You do not Preauthorize care with Optum Health or if You use a non-approved Provider or facility.

SELF-FUNDED MEDICAL INDEMNITY PPO PLAN MEMBER BENEFITS		
	In-Network	**Out-Of-Network**
Calendar Year Deductible	$100 per person, up to $300 per family	$100 per person, up to $300 per family
Calendar-Year Out-of-Pocket Maximum	$2,500 per person, up to $5,000 per family	No Out-Of-Pocket Maximum. You are responsible for 20% of ALL expenses.
Substance Abuse Disorder Inpatient Services	Plan pays 90% of Optum Health's negotiated rates after calendar-year Deductible is applied.	Plan pays 80% of Usual, Customary and Reasonable Charges after calendar-year Deductible is applied.
Substance Abuse Disorder Outpatient Services	Plan pays 80% of Optum Health's negotiated rates after calendar-year Deductible is applied.	Plan pays 80% of Usual, Customary and Reasonable Charges after calendar-year Deductible is applied.

UNITED HEALTHCARE PLAN MEMBER BENEFITS		
	In-Network	**Out-Of-Network**
Calendar Year Deductible	None	None
Calendar-Year Out-of-Pocket Maximum	$2,000 per person, up to $6,000 per family	No Out-Of-Pocket Maximum. You are responsible for 20% of ALL expenses.
Substance Abuse Disorder Inpatient Services	Plan pays 100% after You pay $250 copay.	Plan pays 80% of Usual, Customary and Reasonable Charges after calendar-year Deductible is applied.
Substance Abuse Disorder Outpatient Services	$5 copay per visit.	Plan pays 80% of Usual, Customary and Reasonable Charges after calendar-year Deductible is applied.

How to Use the Program

Preauthorization is required for all Substance Abuse benefits. You must obtain prior authorization through Optum Health. You may contact Optum Health 24 hours a day, 7 days a week toll-free at: 1-877-225-2267 and choose the appropriate menu prompt for assistance. The information You will need to provide Optum Health is as follows:

1. Trust Name: **IBEW / NECA Sound and Communications Health and Welfare Trust Fund**;
2. Employee's name and identification number;
3. Name, date of birth and address of person requesting benefits;
4. Identify which Trust Medical Plan option You are enrolled in: a) Self-Funded Medical Indemnity PPO Plan, b) the United HealthCare Plan, or c) the Kaiser Permanente Plan;
5. Family contact and telephone numbers;
6. Doctor's name and telephone number, if applicable; and
7. Diagnosis.

MEMBER ASSISTANCE PROGRAM (MAP) BENEFITS

Member Assistance Program (MAP) benefits are available if You are covered under the Self-Funded Medical Indemnity PPO Plan, the United HealthCare Plan, or the Kaiser Permanente Plan. Member Assistance Program benefits are provided through a contract with Optum Health.

The MAP is a voluntary, free service which provides confidential assistance to Employees and their eligible Dependents who are experiencing difficulty dealing with personal and work related problems that affect their lives. All contacts with the MAP are kept strictly confidential in accordance with federal and state laws.

The MAP can provide assistance with problems such as:

- Depression, anxiety and stress;
- Substance or alcohol abuse;
- Marital or family issues;
- Financial issues;
- Legal issues;
- Grief and loss;
- Job performance or work-related issues.

The MAP benefit is limited to three (3) sessions per incident per household member per calendar year.

How to Use the Program

You may contact the Member Assistance Program at Optum Health 24 hours a day, 7 days a week toll-free at: 1-877-225-2267 and choose the appropriate menu prompt for assistance. The information You will need to provide Optum Health is as follows:

1. Trust Name: **IBEW / NECA Sound and Communications Health and Welfare Trust Fund**;
2. Employee's name and identification number;
3. Name, date of birth and address of person requesting benefits;
4. Family contact and telephone numbers;
5. What is triggering this referral? What recent event prompted this request?
6. How long has there been a problem? What previous incidents have occurred?
7. To what specific questions are You seeking answers?
8. To whom should Optum Health provide information?

PRESCRIPTION DRUG BENEFITS

You are eligible to use this prescription drug program if You are enrolled in the Self-Funded Medical Indemnity PPO Plan. If You are enrolled in the Kaiser Permanente Plan or the United HealthCare Plan, prescription drug benefits are provided by the Kaiser Permanente Plan or the United HealthCare Plan.

Prescription drug benefits are provided in cooperation with RESTAT, LLC. Information concerning prescription drug benefits, including a list of the pharmacies in the RESTAT retail pharmacy network, can be obtained by calling RESTAT toll-free at 1-800-248-1062. Additional information concerning prescription drug benefits can be obtained at the RESTAT website, www.restat.com.

No benefit is available for prescription drugs obtained from a retail pharmacy outside of the RESTAT network of participating pharmacies. If You use a non-participating pharmacy, You will be responsible for 100% of the cost of the prescription.

Covered Prescription Drugs

The Prescription Drug Program covers drugs that require a written prescription from a Doctor; that must be dispensed by a licensed pharmacist or Doctor; and are not subject to any limitations or exclusions in the Benefit Booklet. The Prescription Drug Program covers contraceptive prescription medication and certain devices. Surgically implantable contraceptive devices, intrauterine devices (IUDs), Depo-Provera and other non-self administered contraceptives are not covered by the Prescription Drug Program but may be covered under the Medical Benefits section of the Plan.

Prescription Drug Options

There are three options for obtaining Your prescription drugs:

1. RESTAT retail pharmacy network (30-day supply)

2. Many pharmacies in the RESTAT retail pharmacy network dispense a 90-day supply of maintenance prescription drugs at the mail order price (90-day supply)

3. Postal Prescription Services (PPS) mail order pharmacy for maintenance prescription drugs (90-day supply)

Each option is discussed below.

RESTAT Retail Pharmacy Network

You can purchase up to a 30-day supply of a prescription drug from a pharmacy in the RESTAT retail pharmacy network by paying the copayment. There are more than 62,000 pharmacies in the RESTAT retail pharmacy network nationwide, including most national chains such as Safeway, CVS, Vons, Walgreens, Ralphs, Rite Aid, Longs, Sav-On, Costco, Target, Lucky and many others (but not Walmart and Sam's Club). You may call RESTAT toll-free at 1-800-248-1062 or go on the web at www.restat.com for a list of pharmacies in the RESTAT Retail Pharmacy network.

You will receive a health benefit card, which will include Your prescription drug information. When obtaining a prescription drug from a pharmacy in the RESTAT Retail Pharmacy network, do the following:

1. Present Your health benefit card at the pharmacy; and

2. Pay the copayment amount.

90-Day Supply of Prescription Drugs from RESTAT Retail Pharmacies

You can purchase up to a 90-day supply of many prescription drugs at certain RESTAT retail pharmacies. Medications taken on a long term basis (called maintenance medication) can be dispensed for ninety (90) days. There will be a lower out-of-pocket cost if You obtain Your maintenance medication through a RESTAT retail pharmacy authorized to dispense a 90-day supply of maintenance medication. You may call RESTAT toll-free at 1-800-248-1062 or go online at www.restat.com for a list of RESTAT pharmacies that dispense a 90-day supply of maintenance medication at the mail order price. **For medications taken on a long-term basis (called maintenance medication), it is mandatory that You purchase the medication from a RESTAT retail pharmacy that will fill a 90-day supply of maintenance medication or from the Postal Prescription Services (PPS) mail order pharmacy.**

90-Day Supply of Prescription Drugs from the Postal Prescription Services (PPS) Mail Order Pharmacy

You can purchase a 90-day supply of many prescription drugs from Postal Prescription Services (PPS) mail order pharmacy. Medications taken on a long-term basis (called maintenance medication) can be dispensed for ninety (90) days. There will be a lower out-of-pocket cost if You obtain Your maintenance medication from the Postal Prescription Services (PPS) mail order pharmacy. **For medications taken on a long-term basis (called maintenance medication), it is mandatory that You purchase the medication from the Postal Prescription Services (PPS) mail order pharmacy or a RESTAT retail pharmacy that will fill a 90-day supply of maintenance medication.**

How to Order by Mail

1. Have Your Doctor write a prescription for a 90-day supply of a maintenance medication.
2. Complete and send the order form to Postal Prescription Services (PPS) with:
   a. New or refill prescription and copayment.
3. Mail Your order to:

   PPS – Postal Prescription Services
   P.O. Box 2718
   Portland, OR 97208-2718

Refills by Phone

Phone refills must be paid with a credit card.

1. Call the touch-tone automated toll-free phone number: 1-800-552-6694
2. Available 24 hours a day / 7 days a week
3. Have the prescription number and credit card ready when You call.

Refills by Internet

1. Log on to www.ppsrx.com
2. Available 24 hours a day / 7 days a week

Prescription Delivery

Please allow two weeks for delivery from the date You mail Your order. Most prescriptions will be delivered by U.S. Postal Service. A re-order form/envelope, an invoice/receipt, renewal/refill cards will accompany each order.

In case of emergency, prescriptions can be shipped overnight for an additional fee. For maintenance drugs You need to start taking right away, ask Your Doctor for two prescriptions: one for a 30-day supply to be filled at a RESTAT retail pharmacy and one for the Postal Prescription Services mail order pharmacy.

Payment

1. Make checks or money orders payable to: Postal Prescription Services
2. Credit cards accepted: Visa, MasterCard, Discover card and American Express
3. Do not send cash.

Summary of Payment Obligations

RESTAT RETAIL PHARMACY NETWORK			
Copayment for Generic Prescription Drugs	**Copayment for Preferred Brand Name Prescription Drugs**	**Copayment for Non-Preferred Brand Name Prescription Drugs**	**Prescription Drug Supply Maximum**
$10	$15 or 20% of drug cost – whichever is greater – up to a $25 maximum	$30 or 30% of drug cost – whichever is greater – up to a $75 maximum	Up to a 30-day supply

MAIL ORDER AND 90-DAY RETAIL PRESCRIPTIONS			
Copayment for Generic Prescription Drugs	**Copayment for Preferred Brand Name Prescription Drugs**	**Copayment for Non-Preferred Brand Name Prescription Drugs**	**Prescription Drug Supply Maximum**
$20	$40 or 20% of drug cost – whichever is greater – up to a $75 maximum	$75 or 30% of drug cost – whichever is greater – up to a $150 maximum	Up to a 90-day supply

Specialty Pharmacy Program for Certain Prescription Drugs

Certain prescription drugs used for treating complex health conditions **MUST** be obtained from the Caremark Therapeutic Services Specialty Pharmacy. Specialty prescription drugs often require special storage and handling requirements, may be injectable or infused and are used to treat complex health conditions including:

Ankylosing Spondylitis
Asthma
Cystic Fibrosis
Deep vein thrombosis
Growth hormone deficiency
Hepatitis B
Hepatitis C
HIV/AIDS
Infertility
Psoriasis
Juvenile Rheumatoid Arthritis
Multiple Sclerosis
Oncology related conditions
Osteoporosis
Psoriatic Arthritis
Prostate cancer
Respiratory Syncytial Virus
Solid organ transplants

Many specialty prescription drugs are not available in a retail pharmacy. The Trust requires You to use the Caremark Therapeutic Services Specialty Pharmacy to provide prescription drugs for treating complex health conditions. The specialty medication is shipped to Your Doctor's office or to Your home, depending on where the medication is administered.

In order to determine whether a prescription drug must be obtained by the Caremark Therapeutic Services Specialty Pharmacy and to obtain a prescription drug that must be obtained from the Caremark Therapeutic Services Specialty Pharmacy, call RESTAT toll-free: 1-877-526-9906. A RESTAT clinical staff specialist will begin the process by verifying eligibility and coverage of the requested medication. When calling RESTAT, identify Yourself as an IBEW / NECA Sound and Communications Health and Welfare Trust participant. The RESTAT clinical staff specialist will contact Your Doctor to verify Your prescription and ensure that You will receive Your next prescription exactly when You need it.

SPECIALTY PHARMACY PRESCRIPTIONS	
Copayment for Specialty Prescription Drugs	20% of the drug cost –up to a $150 maximum

Use of a Brand Name Drug When a Generic Equivalent Drug Is Available

Many prescription drugs are available as a trademark or "brand" name drug and a chemical or "generic" name drug. By law, brand and generic drugs must meet the same standards for safety and effectiveness. Obtaining generic drugs, whenever possible, can provide You with savings directly (by paying a lower copayment) and indirectly (because the Plan saves money – which ultimately benefits You).

If Your Doctor provides You with a prescription for a brand name drug for which a generic equivalent drug is available and indicates "Dispense as written" on the prescription, Your copayment will be the same as the brand name prescription category. If You receive a generic drug prescription from Your Doctor and You wish to substitute it for a brand name drug, in addition to Your copayment, You will be responsible for paying the difference in cost between the generic drug and the brand name drug.

Three-Step Therapy Program for Certain Prescription Drugs (Prior Authorization Required)

A number of brand name prescription drugs have generic or over-the-counter (OTC) equivalents that can be obtained without a prescription. Therefore, certain brand name prescription drugs are not covered unless the following step therapy criteria are met. Step therapy establishes a hierarchy for 15 drug class categories of prescription drugs. Within each class, prescription drugs are divided into three categories or steps as follows:

- Category A (1st Step): prescription drugs are generic and approved for everyone.
- Category B (2nd Step): prescription drugs are approved only after the Category A drug is proved ineffective and Your Doctor has provided RESTAT with clinical notes to support that conclusion.
- Category C (3rd Step): prescription drugs are approved only after Category A and B drugs are proved ineffective and Your Doctor has provided RESTAT with clinical notes to support that conclusion.

Step therapy requires You to use a Category A prescription drug before being authorized to use a more expensive version of the same drug in Category B or C. You must follow the proper steps to have prescription drugs in Categories B and C covered.

In order to obtain a Category B or Category C prescription drug, Your Doctor must provide RESTAT with

clinical notes indicating the Category A prescription drug is not effective and also provide a prior authorization request. Steps You and Your Doctor should follow to have a Category B or Category C prescription drug approved after a Category A prescription drug is proved ineffective are:

- Your Doctor should go to RESTAT's website to download a prior authorization request form at the following address: www.restat.com.
- The prior authorization forms can be found in the Provider section under "Physician Community."
- Your Doctor can also download a copy of RESTAT's step therapy brochure in the Clients section under Forms.
- If You or Your Doctor have questions regarding the step therapy process, please contact RESTAT's customer service line toll-free at: 1-800-248-1062.

There are 16 drug class categories subject to step therapy as follows:

Advair/Symbicort (asthma)
Antidepressants (depression)
Antihypertensive (high blood pressure)
Anti-virals (anti-herpes)
Bisphosphonates (osteoporosis)
Cox-1 sparing NSAIDs (anti-inflammatory)
Glaucoma
Hypnotics (sleep agents)
Intranasal Steroids (allergy)
Overactive Bladder
Prostatic Hyperplasia (receptor blocker/ enzyme inhibitor)
Proton pump inhibitor (GI/ulcer)
Singular (allergic rhinitis)
Statins (high cholesterol)
Topical Immunomodulators
Triptans (migraine)

Two-Step Therapy Program for Antihistamines and Antihistamines Plus Decongestant (Prior Authorization Required)

Step therapy establishes a hierarchy for antihistamines and antihistamines plus decongestants. Category A prescription drugs are approved for everyone. Category B prescription drugs are authorized only after the Category A prescription drug is proved ineffective and Your Doctor has provided RESTAT with clinical notes to support that conclusion. Step therapy requires You to use a Category A prescription drug before being authorized to use a more expensive version of the same drug in Category B. You must follow the proper steps to have prescription drugs in Category B covered. The drug categories are:

Antihistamines

Category A (1st Step): Fexofenadine
Category B (2nd Step): Clarinex (all forms), Xyzal and Allegra (all forms)

Antihistamines Plus Decongestant

Category A (1st Step): Fexofenadine plus pseudoephedrine (12 hours)
Category B (2nd Step): Clarinex-D (12 and 24 hours) and Allegra-D (24 hours)

In order to obtain a Category B prescription drug, Your pharmacy records must reflect that You tried a Category A prescription drug or Your Doctor must provide RESTAT with clinical notes indicating the Category A prescription drug it not effective. Steps You and Your Doctor should follow to have a Category B prescription drug approved after a Category A prescription drug is proved ineffective are:

- Your Doctor should go to RESTAT's website to download a prior authorization request form at the following address: www.restat.com.

- The prior authorization form can be filled in the Provider section under "Physician Community."
- Your Doctor can download a copy of RESTAT's Step Therapy brochure in the Clients section under Forms.
- If You or Your Doctor have questions regarding the Step Therapy process, please contact RESTAT's customer service line at toll-free at: 1-800-248-1062.

Quantity Limitation Program

There may be instances where the pharmacy will dispense less than a 30-day or 90-day supply of a prescription drug. The Quantity Limitation Program manages the quantity of a prescription drug You can receive. The quantity of a prescription drug may be limited to less than a 30-day or 90-day supply based upon current medical findings, manufacturer-labeling information, and/or Food and Drug Administration guidelines. The Quantity Limitation Program targets prescription drugs that are not used on a daily basis but on a per episode basis. Examples include medications for nausea and vomiting, asthma/COPD, cholesterol, osteoporosis, migraine headaches, erectile dysfunction, stomach acid and acute pain. Prescriptions may be limited to a specific number of doses per month or per fill, or by number of days' supply You can receive at one time.

CHARGES FOR MEDICAL AND PRESCRIPTION DRUG BENEFITS THAT ARE NOT COVERED

1. Charges that are, after professional medical review, deemed not Medically Necessary to the Care or Treatment of an Injury or Illness, except for preventative services. Any final review will be based on professional medical opinion.

2. Charges that would not have been made if no Plan existed.

3. Charges that You are not legally obligated to pay.

4. Charges that are in excess of the Usual, Customary and Reasonable Charges for services and material.

5. Charges for treatment by a Provider that is not within the scope of his or her license.

6. Charges for which benefits are not provided in this Plan.

7. Experimental or investigational practices or procedures, and services in connection with such practices or procedures. Costs incurred for any treatment or procedure deemed to be experimental and investigational, as defined on page 131 are not covered.

8. Charges for care, treatment or supplies for any Injury, condition or disease that is occupational (i.e., arising from work or any employment for wage or profit, including self-employment) and which is reimbursable under Worker's Compensation law or similar legislation.

9. Charges for services provided by a person who usually lives in the same household as You, who is a member of Your immediate family, or who is a volunteer.

10. Charges for services or supplies furnished by an agency of the United States Government or foreign government agency, unless excluding them is prohibited by law.

11. Charges for nonemergency care received outside of the United States.

12. In-Hospital medical or surgical care for conditions that do not generally require hospitalization.

13. Any hospitalization for custodial care not involving medical treatment.

14. Charges for confinement in a Skilled Nursing Facility, unless such confinement:

    a. Starts within fourteen (14) days after You have been confined for at least three (3) days in a Hospital for which Room and Board Charges were paid;

    b. Is for treatment of the Illness causing the Hospital confinement;

    c. Is for which a Doctor visits at least once every thirty-four (34) days; and

    d. Is not routine custodial-type care.

15. 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 Preauthorized and approved by Anthem Blue Cross in lieu of hospitalization due to personal injury or sickness.

16. Routine physical or psychological examinations or tests required by employment or government authority, or at the request of a third party such as a school, camp or sport affiliated organization.

17. Physical examinations received from Non-Preferred Providers.

18. Hospital charges for well baby care received from a Non-Preferred Provider.

19. Drugs and medicines that can be obtained without a Doctor's written prescription.

20. Charges for dental services or supplies for treatment of the teeth, gums or alveolar processes. Except the Plan will pay for:

    a. Hospital charges if You are a bed patient; or

    b. Any dental charges covered under the Medical Benefits portion of the Plan.

21. Hearing aids or devices, whether internal, external or implantable, and related fitting or adjustments.

22. Conditions caused by war or any act of war, whether declared or undeclared.

23. Eyeglasses; contact lenses; eye refraction or other examinations in preparation for eyeglasses or contact lenses; eyeglasses or contact lenses prescriptions; vision therapy; orthoptics; and related services. In limited circumstances, certain benefits related to vision care may be covered following cataract surgery or for the repair or alleviation of accidental injury under the Medical Benefits section of the Plan.

24. Radial Keratotomy, LASIK surgery or any other surgical or laser procedures to correct nearsightedness, farsightedness or astigmatism.

25. Corrective shoes or arch supports (orthotics) unless Medically Necessary.

26. Blood pressure monitoring devices.

27. Charges for any treatment for cosmetic purposes or for Cosmetic Surgery. Except the Plan will pay for reconstructive treatment or surgery for one of the following:

    a. Solely due to an Accidental Bodily Injury;

    b. Solely due to surgical removal of all or a part of the breast tissue as the result of an Illness; or

    c. Solely due to a birth defect.

    Cosmetic Surgery does not become reconstructive treatment or surgery because of psychological or psychiatric reasons.

28. Mental retardation, learning disabilities.

29. Psychological enrichment or self-help programs for mentally healthy individuals, including assertiveness training, image therapy, sensory movement groups and sensitivity training.

30. Non-medical self-help or training, such as programs for weight control, and general fitness or exercise programs.

31. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

32. Services and supplies for weight loss or obesity except for surgical procedures that are allowed under the section Covered Charges, paragraph 21, page 31.

33. Pregnancy-related expenses that are not a covered medical expense under the Plan.

34. For any services or supplies provided to a person not covered under the Plan in connection with a surrogate Pregnancy including, but not limited to, the bearing of a child by another woman for an infertile couple.

35. Infertility, including but not limited to procedures, services and supplies for artificial insemination, hormone therapy, in-vitro fertilization or any other direct attempt to induce or facilitate fertility or conception or complications of such procedures.

36. Surgery to reverse a previous elective sterilization.

37. Counseling or treatment in the absence of Illness, including individual or family counseling or treatment for marital, behavioral, family, occupational, religious or educational problems or treatment of normal transitional response to stress. There may, however, be limited benefits under the Member Assistance Program described on page 44.

38. Services related to sex change procedures and complications.

39. Autopsies.

40. Charges for services or purchases before covered by the Plan: The charges for services or purchases will be deemed to have been incurred on the date the services were performed or the date the purchases occurred.

41. All services not specifically listed as benefits or Covered Charges or not reasonably medically linked to or connected with listed benefits, whether or not prescribed by a Provider.

DENTAL BENEFITS

Preferred Provider Dental Organization

The Trust has entered into an agreement with First Dental Health, Inc. a Preferred Provider Dental Organization (PPDO). You can qualify for substantial savings on dental services offered by the Trust's PPDO network of participating dentists. When You choose a dental Provider who is a member of the PPDO network, Covered Charges paid by the Trust are usually higher and You pay less out of pocket. This is because Providers of the PPDO network have contracted to provide services at Negotiated Rates.

Retaining Your Freedom of Choice

The PPDO network is voluntary and presents no limitations to You. You are free to choose any Dental Provider You wish, even if that Dental Provider is not a member of the PPDO network.

The Trust PPDO Network – First Dental Health, Inc.

First Dental Health, Inc. PPDO network is available throughout California.

Any time You need to see a Dental Provider, consult the First Dental Health, Inc. PPDO Network Directory for a list of Dental Providers that are members of the First Dental Health, Inc. PPDO network. You can review the list of PPDO Dental Providers by telephoning the Trust Administrative Office at (408) 288-4400 or toll-free at 1-800-541-8059 or by using the First Dental Health, Inc. website:

1. Go to www.firstdentalhealth.com
2. Click on the "Find a Dentist" button on the left hand side of the screen.
3. Click on "Find a PPO, EOP or ACCESS Dentist."
4. Follow the instructions on the page by entering Your ZIP code.
5. Select the "PPO Subscriber" network.

You can also contact First Dental Health by telephone toll-free at 1-800-334-7244, Monday through Friday, 8 AM to 5 PM Pacific Time.

Dental Benefits

Calendar Year Maximum	$1,500 per person
Orthodontic Lifetime Maximum	$1,000 per person; Dependent Children with cleft palate: $2,500
Deductible	$25 per person per calendar year – applies to Class III – Major Services and Orthodontic Services

Coinsurance Percentage the Plan Pays

Class I – Diagnostic and Preventative Services	100% of UCR* Charges up to Maximum
Class II – Basic Services	80% of UCR* Charges up to Maximum
Class III – Major Services	After Deductible, 60% of UCR* Charges up to Maximum
Orthodontics	After Deductible, 60% of UCR* Charges up to Maximum

* Usual, Customary and Reasonable

Predetermination of Benefits

If contemplating dental work in excess of $300, You are urged to submit to the Trust Administrative Office a copy of the treatment plan, commonly called predetermination of benefits. The dentist performs the examination, including X-rays, and then lists the procedures and charges necessary to complete the treatment. The completed form, together with the X-rays, are then sent to the Trust Administrative Office where the amount payable under the Plan will be computed and You will be informed of the amount that the Plan will pay.

Covered Dental Charges

Dental expenses must be incurred for dental procedures necessary to Your care and treatment and performed by or under the direct supervision of a dentist.

The charge for a dental procedure is incurred on the day the procedure is performed. If a procedure is not completed in one day, the day that the procedure is completed is deemed to be the incurred day for any charges in connection with such procedure.

In the event that more than one dentist furnishes services or materials for one dental procedure, the Plan will pay no more than its obligation had one dentist furnished the services or materials.

The Plan pays a Coinsurance percentage of covered dental expenses as listed and up to the maximums specified on the Dental Benefits listed on page 54. Covered dental expenses include:

Class I – Diagnostic and Preventative Services

- Routine oral examinations including prophylaxis, cleaning, scaling, and polishing, up to two (2) examinations in any twelve (12) consecutive month period.
- Topical fluoride applications, up to two (2) in any twelve (12) consecutive month period; for dependent children who have not attained age 15, up to four (4) in any twelve (12) consecutive month period.
- Supplementary bitewing X-rays up to twice each calendar year.
- Space maintainers for replacement of deciduous prematurely lost teeth for dependent children who have not attained age 15. Space maintainers for primary anterior teeth or missing permanent teeth are not covered.
- Sealant benefits for unrestored, occlusal surfaces of permanent bicuspids and molars. Benefits are limited to one sealant per tooth, during any five (5) year period.

Class II– Basic Services

- Full-mouth X-rays or a panoramic film once in any period of thirty-six (36) consecutive months.
- Dental X-rays required in connection with the diagnosis of a specified condition requiring treatment.
- Extractions and other oral surgery.
- Restorative services using amalgam (silver) fillings on posterior (back) teeth and composite (tooth colored) fillings on anterior (front) teeth for the treatment of carious lesions (decay).
- General anesthesia or intravenous sedation when Medically Necessary and administered in connection with oral or dental surgery.
- Periodontics for the treatment of the gums and supporting structures of the teeth.
- Endodontic procedures for treatment of teeth with diseased or damaged nerves including pulpal therapy and root canal filling.
- Injection of antibiotic drugs by the attending dentist.

Class III – Major Services

- Repair or cementing of crowns, inlays, onlays, bridgework, or dentures or relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining or rebasing in any period of thirty-six (36) consecutive months.
- Onlays or crown restorations to restore diseased or broken teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration.
- Initial installation of fixed bridgework, including inlays and crowns as abutments.
- Initial installation of partial or full removable dentures, including precision attachments and any adjustments during the six-month period following installation.
- Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework or the addition of teeth to an existing partial, removable denture or to bridgework, but only if satisfactory evidence is presented that the
    - Replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed;
    - Existing denture or bridgework cannot be made serviceable and if at least five years have elapsed before its replacement and absent of unusual circumstances as determined by the Board of Trustees in their sole discretion; or
    - Existing denture is an immediate temporary denture that cannot be made permanent and replacement by a permanent denture takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.
- Charges for bridgework where bridgework only can adequately replace dentures.

Orthodontic Benefit

Orthodontic Service procedures for the treatment for correcting malocclusioned teeth up to the lifetime maximum benefit of $1,000 per person. This is separate maximum and is not included in the dental calendar year maximum benefit.

- Expenses incurred for an alternate method of treating a dental condition will be paid at the Usual, Customary and Reasonable Charge for the service that is:
  - Most commonly used nationwide in the treatment of that condition; and
  - Recognized by the dental profession to be appropriate in accordance with accepted nationwide standards of dental practice.

Benefits are limited to the amount specified above. You are responsible for paying the difference in cost between the alternate method selected and the amount reimbursed.

Dental Procedures and Charges Not Covered

The following dental procedures and charges are not covered:

1. Charges for services or materials for which You are not, in the absence of this coverage, legally required to pay.
2. Charges for services or materials received from a dental or medical department maintained by an employer, a mutual benefit association, a labor union or a health benefit plan, or for services or materials furnished by or at the direction of the US government or any state, province or other political subdivision, unless You would be required to pay such charges in the absence of this Plan.
3. Charges for dental procedures You have incurred for the repair of sound natural teeth (including their replacement) required as a result of, and within 24 months of, an Accidental Bodily Injury can be considered for benefit payment under medical expense benefits.
4. Any charge for services and supplies that are cosmetic in nature, including charges for personalization or characterization of dentures, bleaching, or for inlays without onlays.
5. Charges for facings on crowns, or pontics, posterior to the second bicuspid and/or bonding.
6. Charges for sealants, except Type II dental service sealants for dependent children under the age of 15 and for oral hygiene and dietary instruction.
7. Charges for a plaque control program.
8. Charges due to war or any act of war, whether declared or undeclared.
9. Charges for any portion of a dental procedure performed before the effective date of or after the termination of Your coverage for dental expense benefits, except eligible dental charges incurred for dental care furnished within thirty (30) days after termination of coverage for dental expense benefits will be considered eligible for payment if:
   a. The service involves an appliance, or modification of an appliance, for which the impression was taken prior to the termination of Your coverage;
   b. The service involves a crown, bridge or gold restoration for which the tooth was prepared prior to the termination of Your coverage;

c. The service involved root canal therapy for which the pulp chamber was opened prior to the termination of Your coverage; or

d. The procedure is completed within thirty (30) days after termination of Your coverage and You are not otherwise entitled to payment under any other like dental coverage of any type or source.

10. Charges for periodic oral examination and/or prophylaxis performed in excess of two (2) procedures in any twelve consecutive month period.

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

12. Charges for dental appointments that are not kept.

13. Charges for any service or material not furnished by a dentist or Denturist, except a service performed by a licensed dental hygienist or legally licensed professional authorized to perform dental services under the supervision of a dentist, or an X-ray ordered by a dentist.

14. Charges for the replacement of a prosthesis within five years after it was first placed. This exclusion does not apply to the following:

    a. A crown which is needed for restoration only;

    b. Replacement which is needed because of the first time replacement of an opposing full denture or the extraction of natural teeth;

    c. A permanent prosthesis which replaces a stayplate or other temporary prosthesis; and

    d. Replacement of a prosthesis which, while in the mouth, has been damaged beyond repair as a result of an accident which occurs while covered by the Plan. Charges for prosthesis reline no more often than every 36 months.

15. Charges for services, treatment, or procedures that are considered Experimental or Investigative in nature.

Temporomandibular Joint Syndrome (TMJ)

Charges for necessary care and treatment of Temporomandibular Joint Syndrome (TMJ) and associated myofacial pain are covered under the Self-Funded Medical Indemnity PPO Plan but are limited. See page 31, paragraph 23.

Denturists

Payment will be made for services that are within the lawful scope of practice of a Denturist. No payment will be made for services rendered by a Denturist unless:

1. The Denturist has successfully completed a course in advanced oral pathology as prescribed by the Health Division and has received a certificate of completion; or

2. You have received a statement, dated within thirty (30) days prior to the date of treatment, signed by a dentist, or a Doctor, that Your oral cavity is substantially free from disease.

Charges exceeding the Plan's Dental Benefits may not be used to satisfy the Deductible under other provisions of the Plan.

VISION BENEFITS

This benefit is available if You are covered under the Self-Funded Medical Indemnity PPO Plan, the Kaiser Permanente Plan or the United HealthCare Plan. The vision benefits are provided through a contract with Vision Service Plan (VSP). Benefits are available to You from any VSP network Provider or non-VSP Provider.

If You choose to visit a VSP network Provider, there is a copay amount payable by You to the VSP network Provider at the time of the exam and a separate copay when frames and lenses are ordered.

NOTE: The copays do not apply to the exam/materials for contact lenses.

Vision Benefits

1. **Exam:** You are entitled to a comprehensive eye exam to determine the presence of vision problems or other abnormalities. Services shall be provided once every 12 months.

2. **Lenses:** The VSP network Provider will order the proper lenses necessary for Your visual welfare. The Doctor shall verify the accuracy of the finished lenses. Polycarbonate lenses for children are covered in full when dispensed by a VSP network Provider. The Plan covers lenses once every 24 months.

3. **Frame:** VSP covers a frame allowance of up to $130. The frame benefit provides You the choice to select a frame that fits Your lifestyle. If You choose a frame valued at more than Your allowance, You will save 20% on Your out-of-pocket costs. Have Your Doctor help You choose the best frame for You, based on Your VSP coverage. The Plan covers frames once every 24 Months. For information on how Your eligibility for frames may be affected if You receive contact lenses, please see "Contact Lenses" below.

4. **Contact Lenses:** Elective contact lenses are covered up to $130. The contact lens exam (fitting and evaluation) is a separate exam for ensuring proper fit of Your contacts and evaluating Your vision with the contacts. The Plan covers a contact lens exam (fitting and evaluation) in full after a $60 copay. Contact lenses are in lieu of all other benefits (exam, lenses and frames) for that eligibility period. Copays do not apply.

   NOTE: If You get contact lenses, You cannot receive lenses for glasses or contact lenses for another 24 months. You will not be eligible to receive frames again for 24 months. For example, if You get contact lenses in January 2013, the earliest You would be eligible to receive lens and frame again would be January 2015.

   Medically Necessary contact lenses may be prescribed by a VSP network Doctor for certain conditions. A VSP network Doctor must receive prior approval from VSP for Medically Necessary contact lenses. When the VSP network Doctor receives prior approval for such cases, they are fully covered by VSP and are in lieu of all benefits for that eligibility time period. If You receive Medically Necessary contact lenses through a non-VSP Provider, You will be reimbursed according to a Provider schedule (see PROVISIONS FOR A NON-VSP PROVIDER Section).

   Discounted Contact Lens Services: The additional value of VSP is also extended to include a 15% discount on contact lens fitting and evaluation services. The discount does not apply to the cost of the materials. This benefit is available in conjunction with Your $60 copay for Your fitting and evaluation.

5. **Extra Discounts and Savings:**

   - Average 35-40% savings on lens options, such as scratch resistance, anti-reflective coatings and Progressives.

   - 30% off additional glasses and sunglasses, including lens options, from the same VSP Doctor on the same day as Your WellVision Exam, or get 20% off from any VSP Doctor within 12 months of Your last WellVision Exam.

6. **Retinal Screening:** Guaranteed in network member pricing of $39. as an enhancement to Your WellVision exam. Use of retinal imaging, which takes a picture of the back of Your eye, helps Your VSP Doctor find and track possible signs of eye disease.

7. **Low Vision:** The low vision benefit is available if You have severe visual problems that are not correctable with regular lenses. This benefit is subject to the following limitations:

   a. **Prior Authorization** – When a VSP network Doctor suspects a low vision condition and the Doctor requests advance approval prior to beginning service, VSP may authorize supplementary testing by the Doctor to determine the nature of the problem and to allow the Doctor to gather enough facts to propose a treatment plan. The supplementary testing is paid by the Plan with no copay by You.

   b. **Copay** – After supplementary testing, the Doctor submits the treatment plan to VSP consultants for review. If the plan is approved, VSP will authorize benefits, on a copay basis, with 75% of the cost being paid by VSP and 25% of the cost being paid by You.

   c. Maximum Benefit – VSP will pay a maximum of $1,000. (excluding copays) every two years for approved low vision care. The maximum includes the supplementary testing.

Low vision benefits secured from a non-VSP Provider are subject to the same time limits and copay arrangements as described herein for a VSP network Provider. You should pay the non-VSP Provider the full fee. You will be reimbursed in accordance with an amount not to exceed what VSP would pay a Member Provider in similar circumstances. NOTE: There is no assurance that this amount will be within the 25% Copayment feature.

Laser VisionCare Program: VSP has contracted with many of the nation's finest laser surgery facilities and Providers offering You access to laser vision correction surgery for hundreds of dollars less than what You might pay privately. Details about VSP's Laser VisionCare Program, as well as comprehensive information about laser vision correction surgery can be found on the VSP Web site (vsp.com) or by contacting VSP toll-free at 1-800-877-7195.

Sunglasses Following Laser Vision Surgery: Members who have had laser vision surgery can use their frame allowance to buy nonprescription sunglasses from their VSP Provider.

VSP Network Provider and Non-VSP Provider Copay Schedule

There shall be a copay for the exam, payable by You, to the VSP network Provider at the time of the exam; however, if materials (lenses and/or frames) are provided, You must pay an additional copay at the time the materials are ordered as noted below:

Exam	$10
Lenses and/or frames	$25

Any additional care, service and/or material, not covered by this Plan, may be arranged between You and the Doctor.

The copays will not apply toward elective contact lens evaluation/exam and materials.

Provisions for a VSP Network Doctor

The vision benefits provided through VSP provide You with a choice. Selecting a VSP network Doctor assures direct payment to the Doctor and a guarantee of quality and cost control.

Provisions for a Non-VSP Provider

If You choose to go to a non-VSP Provider, services may be secured from any optometrist, ophthalmologist and/or dispensing optician. This Plan then becomes an indemnity Plan reimbursing according to a schedule of allowances. You should pay the Provider the full fee.

Filing a Claim for Non-VSP Provider Services

Following these steps to file a claim if You obtain services and/or materials from a non-VSP Provider:

1. Pay the Provider the full amount of the bill and request an itemized copy of the bill that shows the amount of the eye exam, lens type and frame.

2. Send a copy of the itemized bill(s) to VSP. The following information must also be included in Your documentation:

   - Member's name and mailing address;
   - Member's ID number;
   - Member's Employer or group name; and
   - Patient's name, relationship to member, and date of birth.

Claims must be submitted within twelve months of completion of services. VSP will reimburse in accordance with the schedule below. There is no assurance that the schedule will be sufficient to pay for the exam or the materials. In order to receive reimbursement, please mail Your itemized bill(s) and above documentation to the following address:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Availability of services under this reimbursement schedule is subject to the same time limits and copays as those described on pages 59 through 60. Services obtained from a non-VSP Provider are in lieu of obtaining service from a VSP network Doctor.

Out-Of-Network Reimbursement Schedule

Maximum Reimbursement for services from an Out-Of-Network Provider

PROFESSIONAL FEES	
Exam covered up to	$ 50

MATERIALS	
Single Vision Lenses	$ 50
Bifocal Lenses	$ 75
Trifocal Lenses	$100
Frame	$ 70

CONTACT LENSES *	
Necessary	$210
Elective	$105

* Determination of necessary versus elective contact lenses under the non-VSP Provider reimbursement schedule will be consistent with VSP network Doctor services. Reimbursement for necessary and elective contact lenses is in lieu of all other benefits, including exam and materials for the periods stated.

NOTE: The amounts shown are maximums. The actual reimbursement to You shall be either the amount shown in the "Maximum Reimbursement for Services from a Non-VSP Provider," or the above amount charged by the Provider of such services, whichever is the least amount.

Exclusions and Limitations of Vision Benefits

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division toll-free at 1-800-877-7195.

PATIENT OPTIONS

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.

- Certain limitations on low vision care.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).

NOT COVERED

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an Experimental Nature;
- Costs for services and/or materials above Plan Benefit allowances;
- Services and/or materials not indicated on this Schedule as covered Plan Benefits.

Procedure for Using the Plan

1. When You are ready to obtain vision care services, call Your VSP network Doctor. If You need to locate a VSP network Doctor, call VSP toll-free at 1-800-877-7195 or visit the VSP Web site at vsp.com.

2. When making an appointment, identify Yourself as a VSP member. The VSP network Doctor will also need the covered member's identification number and covered member's group name (IBEW / NECA Sound and Communications Health and Welfare Trust). The VSP network Doctor will contact VSP to verify Your eligibility and Plan coverage. The VSP network Doctor will also obtain authorization for services and materials. If You are not eligible, the VSP network Doctor will notify You.

3. The VSP network Doctor will provide an eye exam and determine if eyewear is necessary. If so, the VSP network Doctor will coordinate the prescription with a VSP-approved, contract laboratory. The VSP network Doctor will itemize any non-covered charges and have You sign a form to document that You received services. VSP will pay the VSP network Doctor directly for covered services and materials. You are responsible for paying the Doctor a $10 copay for the eye exam and a $25 copay for lenses and/or frames. The copays will not apply toward elective contact lenses. You are responsible for any additional costs resulting from cosmetic options, or non-covered services and materials You have selected. Selecting a VSP network Doctor from VSP's network assures direct payment to the Doctor and guarantees quality services and materials.

Coordination of Benefits

If You have dual coverage and are covered by more than one vision plan (whether it be another carrier or another VSP plan), You may:

Use each plan individually (based on what each plan offers) for either two separate exams and/or materials from each plan. For example, contact lenses from one plan and glasses from the other plan or two sets of glasses (one pair from each plan).

or

Choose to have both plans pay for one set of services to offset plan copayment(s), lens options and/or frame overage, up to, but not more than the billed amount.

NOTE: Check with Your VSP Doctor for coordination of benefit details.

Determine Primary and Secondary Plan

- The plan that covers You as an Employee is primary.
- The plan that covers You as a Dependent is secondary.
- If the patient is a Dependent child and is covered under both parents' plans, the parent whose birth date falls first in the calendar year has the primary plan. If the parents are separated or divorced, the parent with custody is primary, or the parent decreed by the court to be responsible is primary.

Request for Appeals

If Your claim for benefits is denied by VSP, in whole or in part, VSP will notify You in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, You may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the covered person for whom a claim for benefits was denied including the name of the VSP enrollee, member identification number of the VSP enrollee, Your name, date of birth, and the name of the Provider of services. You may state the reasons You believe that the claim denial was in error. You may also provide any pertinent documents to be reviewed. VSP will review the claim and give You the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. You or Your authorized representative should submit all requests for appeals to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670-7985
Phone: 1-800-877-7195

Complaints and Grievances

If You have a complaint or grievance regarding VSP service or claim payment, You may communicate Your complaint or grievance to VSP by using a complaint form, which may be obtained by calling the VSP Member Services Department's toll-free number at 1-800-877-7195 Monday through Friday, 5:00 AM – 7:00 PM (PST) and Saturday, 6:00 AM – 2:30 PM, (PST). The completed form should be sent to the address shown above. VSP shall acknowledge receipt of Your grievance within five (5) business days of receipt by VSP. VSP shall also provide a written response to our grievance as required by VSP's licensing statute, the Knox-Keene Health Care Service Plan Act of 1975, as amended. There shall be no discrimination against a member on the basis of filing a complaint or grievance.

The California Department of Managed Health Care is responsible for regulating health service plans. The department's Health Plan Division has a toll-free telephone number 1-800-400-0815 to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers 1-800-735-2929 (TTY) or 1-888-877-5378 (TTY) to contact the department. The department's internet Web site (hmohelp.ca.gov) has complaint forms and instructions online. If You have a grievance against the health Plan, You should first contact Your Plan at 1-800-877-7195 and use the Plan's grievance process before contacting the Health Plan Division.

If You need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the Plan, or a grievance that has remained unresolved for more than sixty (60) days, You may call the Health Plan Division for assistance. The Plan's grievance process and the Health Plan Division's complaint review process are in addition to any other dispute resolution procedures that may be available to You. Your failure to use these procedures does not preclude Your use of any other remedy provided by law.

Liability in Event of Non-Payment

In the event VSP fails to pay the VSP Doctor, You shall not be liable to the Doctor for any sums owed by VSP, other than those not covered by the Plan.

Terms and Cancellations

The contract between the Plan and VSP will continue until terminated by either party giving the other party sixty (60) days prior written notice.

VSP reserves the right to reject any and all claims for services or benefits which are filed more than one hundred eighty (180) days after completion of services.

Vision Benefit Definitions

Coated Lenses – A substance is added to a finished lens on one or both surfaces.

Covered Person – The Employee, and their eligible and enrolled Dependents, of the Employer participating in this program.

Group – The entity that contracts with VSP on behalf of its members.

Materials – Lenses, frame, low vision aids, and contact lenses.

Orthoptics – The teaching and training process for the improvement of visual perception and coordination of the two eyes for efficient and comfortable binocular vision.

Oversize Lenses – Larger than standard lens blank.

Photochromic Lenses – Lenses that change color with intensity of sunlight.

Plan Administrator – United Administrative Services.

Plano Lenses – Lenses with no refractive power.

Polycarbonate Lenses – The most impact-resistant lens. Thinner than regular plastic lenses. Appropriate for active lifestyles, especially kids.

Professional Service – Exam, material selection, fitting of glasses, and related adjustments.

Progressive Lenses – A multifocal lens with no distinct lines. Changes from distance correction in the top half of the lens to reading correction in the bottom half of the lens.

Tinted Lenses – Lenses which have additional substance added to produce constant tint (e.g., pink, green, gray, and blue).

LIFE INSURANCE BENEFITS

FOR CATEGORY 1 (BARGAINING UNIT) EMPLOYEES ONLY

Life insurance benefits are available to Category 1 (bargaining unit) Employees only. An employee who does not qualify for insurance under the Trust, full time members of the armed forces of any country and Employees making payments under COBRA are not eligible for life insurance benefits. Life insurance is provided through a group insurance policy with Standard Insurance Company.

Amount of Insurance

The Plan provides $15,000 of life insurance coverage.

Reductions in Insurance

Your life insurance amount will be reduced based on Your age, as shown below:

Age	Benefit
70 through 74	$9,750
75 or more	$7,500

Life Insurance Effective Date

Your life insurance becomes effective on the later of a) the Group Policy Effective Date; b) the effective date of Your Employer's participation under the Group Policy and c) the first day of the calendar month following the last day of any month in which You have accumulated sufficient money in Your Reserve Dollar Bank Account to meet the required amount for benefit eligibility and if Contributions have been made and received in Your name for the hours You have worked for one or more participating Employers.

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 Trust;

2. The date the group policy terminates;

3. The date You cease to be eligible for the Plan due to the lack of Employer, or a combination of Employer and Employee, Contributions for health and welfare benefits. A self-payment under COBRA WILL NOT extend Your life insurance benefits; or

4. The date You become a full-time member of the armed forces of any country (except as provided under the Uniformed Services Employment and Reemployment Act).

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 eighty (180) days;

3. Satisfactory proof of Total Disability is furnished to Standard Insurance Company; and

4. Proof is submitted to Standard Insurance Company no later than 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 qualified by training, education or experience.

Premium payment must continue to be made during the first one hundred 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, subject to reductions in insurance due to age. 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 the 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 65.

Accelerated Benefit

1. **Qualifying for an Accelerated Benefit**

   If You qualify for a Waiver of Premium Benefit and You have a Qualifying Medical Condition You have the option of accelerating the life insurance benefit payment. 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 12 months.

2. **Application for Accelerated Benefit**

   You must have at least $10,000 of insurance in effect to be eligible.

   You must apply for an Accelerated Benefit. To apply, You must give Standard Insurance Company satisfactory proof of loss on its form. Proof of loss must include a statement from a Physician that You have a Qualifying Medical Condition.

   Standard Insurance Company may have You examined at its expense in connection with Your claim for an Accelerated Benefit. Any examination will be conducted by one or more Physicians of its choice.

3. Amount of Accelerated Benefit

You may receive an Accelerated Benefit of up to 75% of Your life insurance. The minimum Accelerated Benefit is $5,000 or 10% of Your insurance.

If the amount of Your insurance is scheduled to reduce within 24 months following the date You apply for the Accelerated Benefit, Your Accelerated Benefit will be based on the reduced amount.

If Your insurance is scheduled to end within 24 months following the date You apply for the Accelerated Benefit, You will not be eligible for the Accelerated Benefit.

You may elect an Accelerated Benefit once in Your lifetime. The Accelerated Benefit will be paid to You 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.

The amount of Your life insurance after payment of the Accelerated Benefit will be:

a. The amount of Your life insurance as if no Accelerated Benefit had been paid; minus

b. The amount of the Accelerated Benefit; minus

c. An interest charge calculated as follows:

   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; or

   ii. The date You have a right to convert.

However, Your life insurance will not be reduced to less than 10% of Your original amount.

4. 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, separation 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; or

e. You have previously received an Accelerated Benefit under the group policy.

Right to Convert

1. Exclusions

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

Your life insurance, whether under the Group Policy or continued under Waiver of Premium, ends or is reduced for any reason except failure to make a required premium or payment of an accelerated benefit; and

a. Your life insurance, whether under the Group Policy or continued under Waiver of Premium, ends or is reduced for any reason except failure to make a required premium or payment of an 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 or is reduced.

   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 that 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 five 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 this group policy, minus any other group life insurance for which You become eligible during the thirty-one (31) days after termination of this group policy.

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 its 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**.

Filing Life Insurance Claims

1. Filing a Claim

Claims should be filed on Standard Insurance Company forms. You may obtain a claim form by calling the Trust Administrative Office.

2. Time Limits 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 that ninety (90) -day period.

Proof of Loss for Waiver of Premium must be provided within 12 months after the end of Your one hundred eighty (180) day Waiting Period. Further proof of loss will be required at reasonable intervals, but not more often than once a year after You have been continuously Totally Disabled for two years.

If proof of loss is filed outside 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. That is not subject to any exclusions; and

c. That 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 its expense at reasonable intervals. Any examination will be conducted by specialists of its choice.

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

5. Time of Payment

Benefits will be paid within sixty (60) days after proof of loss is satisfied.

6. Notice of Decision on Claim

Standard Insurance Company (Standard) will evaluate a claim for benefits promptly after Standard receives it. With respect to all claims except Waiver of Premium claims, within ninety (90) days after Standard receives the claim, it will send the Claimant:

a. A written decision about the claim; or

b. A written notice that Standard is extending the time to decide the claim for an additional ninety (90) days.

With respect to Waiver of Premium claims, within forty-five (45) days after Standard receives the claim, it will send the Claimant:

a. A written decision about the claim; or

b. A written notice that Standard is extending the time to decide the claim for an additional thirty (30) days.

Before the end of the extension for a Waiver of Premium claim, Standard will send the Claimant:

a. A written decision about the claim; or

b. A written notice that Standard is extending the time to decide the claim for an additional thirty (30) days.

If an extension is due to the Claimant's failure to provide information necessary to decide a Waiver of Premium claim, the extended time for deciding the claim will not begin until the Claimant provides the information or otherwise responds.

If Standard extends the time to decide a claim, Standard will notify the Claimant of the following:

a. The reason(s) for the extension;

b. When Standard expects to decide the claim;

c. An explanation of the standards on which entitlement to benefits is based;

d. The unresolved issues preventing a decision; and

e. Any additional information Standard needs to resolve these issues.

If Standard requests additional information, the Claimant will have forty-five (45) days to provide the information. If the Claimant does not provide the requested information within forty-five (45) days, Standard may decide the claim based on the information it has received.

If Standard denies any part of the claim, it will send the Claimant a written notice of denial containing:

a. The reasons for Standard's decision;

b. Reference to the parts of the group policy on which the decision is based;

c. Reference to any internal rule or guideline relied upon in deciding a Waiver of Premium claim;

d. A description of any additional information needed to support the claim;

e. Information concerning the Claimant's right to review Standard's decision; and

f. Information concerning the Claimant's right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act if the claim is denied on review.

7. Review Procedure

If all or part of a claim is denied, the Claimant may request a review. The Claimant must request a review in writing within the following time frames:

a. Within one hundred eighty (180) days after receiving notice of denial of a claim for Waiver of Premium;

b. Within sixty (60) days after receiving notice of denial of any other claim.

The Claimant may send to Standard written comments or other items to support the claim. The Claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for the copies. Standard's review will include any written comments or other information the Claimant submits to support the claim.

Standard will review the claim promptly after it receives the request for review. With respect to all claims except Waiver of Premium claims, within sixty (60) days after Standard receives the request for review, it will send the Claimant:

a. A written decision on review; or

b. A notice that Standard is extending the review period for sixty (60) days.

With respect to Waiver of Premium claims, within forty-five (45) days after Standard receives the request for review, it will send the Claimant:

a. A written decision on review; or

b. A written notice that Standard is extending the review period for forty-five (45) days.

If the extension is due to the Claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the Claimant provides the information or otherwise responds.

If Standard extends the review period, it will notify the Claimant of the following:

a. The reasons for the extension;

b. When it expects to decide the claim on review; and

c. Any additional information it needs to decide the claim.

If Standard requests additional information, the Claimant will have forty-five (45) days to provide the information. If the Claimant does not provide the requested information within forty-five (45) days, Standard may conclude its review of the claim based on the information it has received.

With respect to Waiver of Premium claims, the person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the initial denial decision was based on a medical judgment, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgment and will not be subordinate to that person. The Claimant may request the names of the medical or vocational experts who provided advice to Standard about a claim for Waiver of Premium.

If Standard denies any part of the claim on review, the Claimant will receive a written notice of denial containing:

a. The reason(s) for Standard's decision;

b. Reference to the part(s) of the group policy on which the decision is based;

c. Reference to any internal rule or guideline relied upon in deciding a Waiver of Premium claim;

d. Information concerning the Claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim; and

e. Information concerning the Claimant's right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act.

The group policy does not provide voluntary alternative dispute resolution options. However, You may contact the local office of the United States Department of Labor or Your state insurance commissioner for assistance.

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 Trust Administrative Office 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 Trust Administrative Office.

You may obtain a Beneficiary designation form by calling the Trust Administrative Office.

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 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 a Beneficiary, benefits will be paid in equal shares to the first surviving class of the classes below:

a. Your spouse or Domestic Partner. Domestic Partner means an individual recognized as such under applicable law;

b. Your children;

c. Your parents;

d. Your brothers and sisters;

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, 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 Standard Insurance Company 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 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 toll-free telephone number of Standard Insurance Company are:

Standard Insurance Company
900 SW 5th Ave.
Portland, OR 97204-1235
1-800-628-8600

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE BENEFITS

FOR CATEGORY 1 (BARGAINING UNIT) EMPLOYEES ONLY

Accidental Death and Dismemberment (AD&D) insurance benefits are available to Category 1 (bargaining unit) Employees only. An employee who does not qualify for insurance under the Trust, full time members of the armed forces of any country and Employees making payments under COBRA are not eligible for AD&D Insurance benefits. AD&D Insurance is provided through a group insurance policy with Standard Insurance Company.

AD&D Insurance Benefits

AD&D Insurance provides benefits for dismemberment or death resulting from accidental bodily Injuries. The AD&D 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, that:

   a. Is caused solely and directly by an accident;

   b. Occurs independently of all other causes; and

   c. Occurs within three hundred sixty-five (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 of Insurance**

   The amount payable is:

LOSS	AMOUNT
Life	$15,000
One hand, one foot, or sight of one eye	$ 7,500
Two or more of the above losses	$15,000

   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 AD&D Insurance benefit is payable; and

b. You were wearing and properly utilizing 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 and shoulder restraint, or other restraint approved by the Federal Vehicle Safety Standard of 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, whether civil or international, or 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 a 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 IBEW / NECA Sound and Communications Health and Welfare Trust;

b. The date Your Life Insurance ends

c. The date Your Waiver of Premium begins

d. The date the group policy terminates;

e. The date You cease to be eligible for the Plan due to a lack of Employer, or a combination of Employer and Employee, Contributions for the health and welfare benefits. A self-payment under COBRA WILL NOT extend Your AD&D Insurance benefit; or

f. The date You become a full-time member of the armed forces of any country (except as provided under the Uniformed Services Employment and Reemployment Act).

Filing Accidental Death and Dismemberment 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 Trust Administrative Office.

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. That is not subject to any exclusions; and

c. That 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 its expense at reasonable intervals. Any such examination will be conducted by specialists of its choice.

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

5. Time of Payment

Benefits will be paid within sixty (60) days after proof of loss is satisfied.

6. Notice of Decision on Claim

Standard Insurance Company (Standard) will evaluate a claim for benefits promptly after Standard receives it. Within ninety (90) days after Standard receives the claim, it will send the Claimant:

a. A written decision about the claim; or

b. A written notice that Standard is extending the time to decide the claim for an additional ninety (90) days.

If Standard extends the time to decide the claim, Standard will notify the Claimant of the following:

a. The reason(s) for the extension;

b. When Standard expects to decide the claim;

c. An explanation of the standards on which entitlement to benefits is based;

d. The unresolved issues preventing a decision; and

e. Any additional information Standard needs to resolve these issues.

If Standard requests additional information, the Claimant will have forty-five (45) days to provide the information. If the Claimant does not provide the requested information within forty-five (45) days, Standard may decide the claim based on the information it has received.

If Standard denies any part of the claim, it will send the Claimant a written notice of denial containing:

a. The reason(s) for Standard's 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;

d. Information concerning the Claimant's right to review Standard's decision; and

e. Information concerning the Claimant's right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act if the claim is denied on review.

7. Review Procedure

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

The Claimant may send to Standard written comments or other items to support the claim. The Claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for the copies. Standard's review will include any written comments or other information the Claimant submits to support the claim.

Standard will review the claim promptly after it receives the request for review. Within sixty (60) days after Standard receives the request for review, it will send the Claimant:

a. A written decision on review; or

b. A notice that Standard is extending the review period for sixty (60) days.

If the extension is due to the Claimant's failure to provide information necessary to decide the claim on review, the extended time period for review of the claim will not begin until the Claimant provides the information or otherwise responds.

If Standard extends the review period, it will notify the Claimant of the following:

a. The reason(s) for the extension;

b. When it expects to decide the claim on review; and

c. Any additional information it needs to decide the claim.

If Standard requests additional information, the Claimant will have forty-five (45) days to provide the information. If the Claimant does not provide the requested information within forty-five (45) days, Standard may conclude its review of the claim based on the information it has received.

If Standard denies any part of the claim on review, the Claimant will receive a written notice of denial containing:

d. The reason(s) for Standard's decision;

e. Reference to the parts of the group policy on which the decision is based;

f. Information concerning the Claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim; and

g. Information concerning the Claimant's right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act.

The group policy does not provide voluntary alternative dispute resolution options. However, You may contact the local office of the United States Department of Labor or Your state insurance commissioner for assistance.

Assignment

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

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

The Beneficiary(ies) You name for life insurance will be Your Beneficiary for AD&D benefits. 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 Trust Administrative Office 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 Trust Administrative Office.

You may obtain a Beneficiary designation form by calling the Trust Administrative Office.

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 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 or Domestic Partner. Domestic Partner means an individual recognized as such under applicable law;

b. Your children;

c. Your parents;

d. Your brothers and sisters;

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 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 Standard Insurance Company 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 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.

Address and Telephone Number

The address and toll-free telephone number of Standard Insurance Company are:

Standard Insurance Company
900 SW 5th Ave.
Portland, OR 97204-1235
1-800-628-8600

SHORT-TERM DISABILITY (STD) BENEFITS

FOR CATEGORY 1 (BARGAINING UNIT) EMPLOYEES ONLY

This benefit is designed to partially replace a participating Category 1 (bargaining unit) Employee's lost wages while disabled. This benefit is paid from Trust Fund assets.

Establishing and Maintaining Eligibility

STD benefits are provided only for Category 1 (bargaining unit) Employees. Dependents are not eligible for this benefit, nor are Category 2 (non-bargaining) Employees or their Dependents. Eligibility for STD benefits is the same as for Medical Benefits, with the exception that there is no continuing eligibility for STD benefits if eligibility at the time the Total Disability began was based on a COBRA self-payment or Family and Medical Leave Act provisions.

The disability occurrence 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, is not eligible for this benefit.

If an Employee who is otherwise eligible suffers a Total Disability after working sufficient hours to establish eligibility, but prior to eligibility for benefits from the Trust beginning, the Employee will be eligible for STD benefits beginning on the first day of the month in which eligibility begins. In such situations, any applicable waiting period will begin on the first day of the month in which the Employee becomes eligible.

Eligibility for Benefits

Eligible Employees are entitled to receive STD benefits if they are Totally Disabled as a result of a non-occupational accidental Injury or sickness, have met any waiting period and have submitted all required documentation to the Trust Administrative Office.

Definition of Disability

Total Disability is defined as the complete inability of the Employee to perform any and every duty of his or her occupation within the Electrical Industry as the result of an Accidental Bodily Injury, sickness, Mental Illness, Substance Abuse or Pregnancy for which the Employee is under the continuous care of a Physician. For purposes of certifying Total Disability a Physician is defined as a doctor of medicine, osteopathy, psychology, or podiatry, a dentist, a chiropractor or a certified nurse practitioner practicing within the scope of his or her license.

Benefit Payable

If an eligible Employee is disabled due to an accidental Injury or sickness, that Employee shall be eligible to receive STD benefits for up to twenty-six (26) weeks for any One Continuous Period of Disability. Benefits will begin on the first day of a disability if the disability is the result of an Accidental Bodily Injury or on the eighth day of disability if the disability is due to a sickness. If disability due to a sickness requires hospitalization, benefits will start on the first day of hospitalization. Periods of disability separated by less than two weeks active work on a regular basis shall be considered one period of disability unless the subsequent Total Disability is due to an accidental Injury or sickness entirely unrelated to the causes of the previous Total Disability and commences after the Employee has returned to active full-time employment for at least one full day.

Amount of Benefit

First thirteen (13) weeks:	$100 per week
Next thirteen (13) weeks:	$150 per week

The weekly benefit will be paid on the basis of a regular five-day work week, Monday through Friday. No benefits are paid for Saturdays or Sundays. If benefits are payable for a partial week, You will receive one-fifth of the weekly benefit for each day of disability.

Pregnancy

If a female Employee is disabled due to maternity or a Pregnancy-related condition (childbirth, abortion, miscarriage or complications from Pregnancy), the disability will be treated as a disability due to sickness. Benefits are payable for any one Pregnancy if the Employee is eligible for benefits. The maximum benefit period due to Pregnancy is twenty-six (26) weeks.

Termination of Eligibility

An Employee's eligibility for the STD benefit will end at the earliest of the following dates:

1. The date the STD Plan or the Trust terminates;
2. The day before the Employee enters the Armed Forces for active duty (except for temporary periods of active duty of thirty-one (31) days or less;
3. The date for which the last required Contribution payment is made on behalf of the Employee; or
4. The date the Employee ceases to be eligible under the applicable Collective Bargaining Agreement or the eligibility terms of the Plan.

Application for STD Benefits

An application for STD benefits is available from the Trust Administrative Office. Applications must be accompanied by a Physician's statement of Total Disability and must be submitted within sixty (60) days of the Total Disability beginning, unless the Employee provides satisfactory evidence that he/she has remained continuously disabled from the inception of the disability through the date the application is received.

Exclusions and Limitations on STD Benefits

STD benefits for otherwise eligible Employees are not available or will be terminated if:

1. The Employee fails to file a timely or complete required benefit application or fails to provide adequate documentation obtained from a Physician establishing he or she is Totally Disabled;
2. The Employee is not under the continuous care of a Physician for the Total Disability;
3. The Employee has exhausted the maximum benefit available under the Plan;
4. The Employee has or had a right under any workers compensation or occupational disease law for the Total Disability. Benefits will be advanced pursuant to the Plan's Third Party Reimbursement Requirements if no payment from a worker's compensation insurance company is being made that is or appears to be related to the Total Disability and no settlement has been made on the Employee's claim;

5. The Employee's Total Disability was sustained during the course of any employment or self-employment for wage or profit for which there is no workers compensation insurance coverage;
6. For any disability for which You perform light-duty work;
7. The Employee's Total Disability is the result of an Accidental Bodily Injury or sickness which is, or appears to be, the responsibility of a third-party for which payment is or may be made by the third-party or by an insurance company on the third party's behalf.
8. The Employee's Total Disability is the result of war or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature).
9. For any disability or days of disability caused by Substance Abuse:
    a. If You are not undergoing a covered course of treatment;
    b. Beyond the date the covered course of treatment is completed; or
    c. For which Medical Benefits are not payable by the Plan, including a course of treatment that is terminated before it is completed.
10. The Employee's disability is due to an intentional self-inflicted Injury, while same or insane.
11. For any period of disability when You are confined for any reason in a penal or correctional institution.
12. For any disability caused while committing or attempting to commit an assault or felony, or Your active participation in a violent disorder or riot.
13. For any disability caused by an attempt to commit or by the commission of a crime or felony.
14. For any disability caused or contributed to by Your being engaged in an illegal occupation.
15. For any condition that does not meet the Plan's definition of Total Disability and cannot be verified by an examination by a Physician designated by the Trustees.
16. The date the STD Plan or the Trust terminates. Note: An Employee who is Totally Disabled and receiving STD benefits at the time his or her Employer ceases participating in the Trust will continue to do so up to the maximum time period so long as he or she remains Totally Disabled and is otherwise eligible for benefits.

Any payments made pursuant to a Collective Bargaining Agreement while an Employee is Totally Disabled will not affect the Employee's right to receive STD benefits.

Right for Independent Medical Examination

The Board of Trustees or its agents, in their discretion, may require the Employee to undergo an independent medical examination by a Physician, vocational expert, functional expert, or other medical or vocational professional to certify that he or she is or remains Totally Disabled under the terms of the Plan. Any such examination will be at the Plan's expense and as reasonably required by the Plan.

Social Security (FICA) Tax Reporting

Any short-term disability benefit payments made are subject to Federal income tax and, if applicable, state income tax. The Trust Administrative Office 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.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

FOR CATEGORY 1 (BARGAINING UNIT) EMPLOYEES ONLY

The Plan includes a Health Reimbursement Arrangement (HRA). If You are eligible, the Plan sets up and maintains an account for You to use for reimbursement of eligible health care expenses on a tax-free basis.

HRA Eligibility

You are eligible to participate if You work under a Collective Bargaining Agreement that allows for Contributions to an HRA on Your behalf.

While Contributions are only made on Your behalf while You are working for a participating Employer, You do not have to be an active participant to use the money in Your HRA. Furthermore, Your account can be used to pay eligible expenses for any of Your eligible dependents. This allows You to use Your HRA for reimbursement of future expenses, such as the cost of continued coverage when You are not working enough hours or at retirement. In addition, Your HRA balance continues to be available to Your surviving spouse and Dependent children in the event of Your death, provided they were covered as Dependents under the Plan. However, if You have no medical qualified Dependent upon Your death, Your HRA account balance will revert to the general assets of the Trust.

You continue to be eligible to use Your HRA for reimbursement of eligible health care expenses for three years from the date work hours were last reported (that is, when You left covered employment; this does not apply to retirement). Retirement is satisfied by proof of retirement under the Social Security Act, NEBF, I.B.E.W. District No. 9 Pension Plan or any other IBEW-NECA sponsored retirement plan. In the event of Your death, Your surviving spouse and Dependent children will continue to be eligible for reimbursement of eligible expenses until the earliest of:

- The date Your HRA account balance reaches zero;
- The HRA terminates; or
- Three years from the date work hours were last reported for You (however, this does not apply when hours are not reported due to retirement).

If You go on a qualifying leave under FMLA or USERRA, the Plan will continue to maintain Your benefits on the same terms and conditions as if You were still an active Employee.

Establishing an HRA Account

When You work for a participating Employer, an HRA Contribution will be made on Your behalf and credited to Your HRA for each hour that You work. In other words, the more hours You work, the more Contributions are made to Your HRA. Please note that only Employer HRA Contributions made on Your behalf are credited to Your HRA; You may not make Contributions to Your account.

Once the Plan establishes Your account, You may submit claims for eligible health care expenses incurred by You, Your spouse, and/or Your Dependents. In no event will benefits be provided in the form of cash or any other taxable or non-taxable benefit other than reimbursement for eligible expenses. Payments will only be made to You, or to Your Beneficiary in the event of Your death. There is no assignment of benefits to Providers and no benefit payments may be paid to Providers.

Your HRA Balance

Your HRA balance is the total of Employer Contributions made on Your behalf for the HRA, minus any reimbursements You request from Your HRA. The amount available for reimbursement of eligible expenses is the amount credited to Your HRA. Contributions made on Your behalf will not be credited to Your HRA until after they are received by the Plan, but always within thirty (30) days after they are received. In other words, there may be a lag between the time Contributions are required on Your behalf and when they are available for You to use. Keep in mind that any unused amounts in Your HRA at the end of a calendar year are carried over into the next year.

Unused balances remaining in Your HRA at the end of a calendar year roll over into the next year, even into retirement. This allows You to save for future health expenses. Once You are no longer eligible for Plan coverage, Your HRA may be carried forward for up to three years after Your Plan coverage ends (for reasons other than retirement). Keep in mind, however, that no further Employer Contributions will be made to Your account once You terminate covered employment. Your HRA balance will be carried forward until no balance remains or until three years after You are no longer covered under the Plan. During the three-year period, You may continue to use the money in Your HRA for reimbursement of eligible health care expenses as long as a balance remains in Your account.

In the event of Your death, Your surviving spouse continues to be entitled to reimbursements from Your HRA account until the earlier of the date Your HRA account reaches a zero balance, the HRA ends, or three years from the date work hours were last reported (that is, when You left covered employment; this does not apply to retirement nor does it apply if hours were reported within the 2 calendar months prior to Your death). Your other Dependents covered under the HRA may continue participation in the HRA until the earlier of the date they no longer meet the Plan's definition of Dependent, the date Your HRA account reaches a zero balance, or the HRA ends. If You do not have any Dependents, any amounts left in Your HRA account will not be paid to any other individual. In this instance, all amounts remaining are forfeited and revert to the general assets of the Trust. In no event will remaining assets be paid in cash to any person.

Reimbursable Expenses

You can use the money in Your HRA to pay for eligible health care expenses incurred by You, Your spouse and/or Your eligible Dependents. Please note that as with any Plan coverage, Your spouse and/or Your other Dependents must meet the Plan's definition of Dependent for their expenses to be eligible for reimbursement. Any reimbursements You submit for Your spouse's and/or Your Dependents' expenses will be charged against Your HRA.

In general, health care expenses eligible for reimbursement include, but are not limited to:

- Hospital, Doctor, and dentist bills, and prescription drugs;
- Amounts You pay for Deductibles, copayments, and Coinsurance;
- Premiums for group health plan coverage (provided premiums are not paid through salary reduction Contributions under the terms of a Code Section 125 Plan or any plan that provides for premium payment with pre-tax dollars), COBRA Continuation Coverage, and Medicare Parts B, C, and D.

Following is a listing of the type of expenses that may be eligible for reimbursement from the Plan's HRA. This list is based on IRC Section 213 and is taken from the Department of Treasury, Internal Revenue Service, Publication 502, Medical and Dental Expenses. Please note that not all IRC Section 213 expenses are eligible for reimbursement. For more detailed information, contact the IRS or visit www.irs.gov/pub/irs-pdf/p502.pdf.

Reimbursable Expenses

- Acupuncture
- Alcoholism, including Inpatient treatment at a therapeutic center for alcohol addiction, including meals and lodging provided by the center during treatment.
- Artificial limbs.
- Artificial teeth, for other than cosmetic reasons.
- Birth control pills prescribed by a Doctor.
- Breast reconstruction surgery following a mastectomy for cancer.
- Chiropractor.
- Contact lenses needed for medical reasons, including cost of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner.
- Crutches (rental or purchase).
- Dental treatment, including fees paid to dentists for X-rays, fillings, braces, extractions, dentures, etc. (but *Teeth Whitening*, as described later, is not covered).
- Diagnostic devices used in diagnosing and treating Illness and disease.
- Drug addiction for Inpatient treatment at a therapeutic center for drug addiction, including meals and lodging at the center during treatment.
- Eye or vision correction surgery, including eye surgery to treat defective vision, such as laser eye surgery or radial keratotomy.
- Eyeglasses needed for medical reasons, including fees paid for eye examinations.
- Fertility enhancement to overcome an inability to have children, including:
    - Procedures, such as *in vitro* fertilization and temporary storage of eggs or sperm.
- Surgery, including an operation to reverse prior surgery that prevented the person from having children.
- Health institute if the treatment is prescribed by a Physician and the Physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or Illness of the individual receiving the treatment.
- Hearing aids including batteries to operate it.
- Home Care (see *Nursing services*).
- Hospital services for Inpatient care at a Hospital or similar institution if a principal reason for being there is to receive medical care; this includes meals and lodging (see *Lodging*).
- Laboratory fees for medical care.

Reimbursable Expenses, continued

- Legal abortion.
- Legal medical services provided by Physicians, surgeons, specialists, and other medical practitioners.
- Lodging at a Hospital or similar institution while away from home if:
  - The lodging is primarily for and essential to medical care;
  - The medical care is provided by a Doctor in a licensed Hospital or in a medical care facility related to or the equivalent of, a licensed Hospital;
  - The lodging is not lavish or extravagant under the circumstances; and
  - There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

  Amounts for lodging cannot be more than $50 for each night for the individual receiving medical care and a person traveling with that individual. Expenses are not eligible if treatment is not received from a Doctor in a licensed Hospital or in a medical care facility related to, or the equivalent of, a licensed Hospital or if the lodging is not primarily for or essential to the medical care received.
- Medical supplies, such as bandages used to cover torn skin.
- Medicines that require a prescription by a Doctor for use by an individual, including insulin.
- Mentally retarded special home, which includes the cost of keeping a mentally retarded person in a special home, not the home of a relative, on the recommendation of a psychiatrist to help the person adjust from life in a mental Hospital to community living.
- Nursing home medical care (including care in a home for the aged or similar institution), meals, and lodging if a principal reason for being there is to get medical care.
- Nursing services, including wages and other amounts paid for nursing services provided by a nurse licensed in the jurisdiction where providing services.
- Operations or surgery, when legal and not preformed for unnecessary Cosmetic Surgery (see *Cosmetic Surgery*).
- Optometrist.
- Organ donors (see *Transplants*).
- Osteopath.
- Over-the-counter (OTC) medications obtained by a prescription from Your Doctor or Physician.
- Oxygen, including equipment, to relieve breathing problems caused by a medical condition.
- Prosthesis.

Reimbursable Expenses, continued

- Psychiatric care, including the cost of supporting a mentally ill Dependent at a specially equipped medical center where the Dependent receives medical care.

- Psychoanalysis (however, psychoanalysis that is part of required training to be a psychoanalyst is not eligible).

- Psychologist.

- Sterilization (a legally performed operation to make a person unable to have children).

- Stop-smoking programs (this does not include stop-smoking drugs that do not require a prescription, such as nicotine gum or patches).

- Telephone special equipment that lets a hearing-impaired person communicate over a regular telephone, including teletypewriter (TTY) and telecommunications device for the deaf (TDD) equipment as well as equipment repair costs.

- Television equipment that displays the audio part of television programs, such as subtitles, for hearing-impaired persons (this is an adapter that attaches to a regular set or some of the costs associated with a specially equipped television that exceeds the cost of the same model regular television set).

- Therapy received as medical treatment (not including massage therapy).

- Transplants as a donor or possible donor of an organ.

- Vasectomy.

- Wheelchair used mainly for the relief of sickness or disability, and not just to provide transportation to and from work; this includes the cost of operating and maintaining the wheelchair.

- Wig purchased upon the advice of a Physician for the mental health of a patient who has lost all hair from disease.

- X-rays for medical reasons.

Expenses Not Eligible for Reimbursement

Expenses that are not eligible for reimbursement from the HRA (as defined by Section 213(d) of the Internal Revenue Code) include, but are not limited to:

- Over-the-counter (OTC) medications obtained without a prescription from Your Doctor or Physician.

- Long-term care services.

- Cosmetic or reconstructive surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, personal Injury resulting from an accident or trauma, or disfiguring disease.

- The salary expense of a nurse to care for a healthy newborn at home.

- Funeral and burial expenses.

Expenses Not Eligible for Reimbursement, continued

- Household and domestic help (even though recommended by a qualified Physician due to You or Your Dependent's inability to perform physical housework).
- Massage therapy.
- Home or automobile improvements.
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition, such as obesity.
- Social activities, such as dance lessons (even though recommended by a Physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Vitamins and food supplements, even if prescribed by a Physician.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a Physician.
- Any item that does not constitute "medical care" as defined under Code Section 213.
- Premiums paid through salary reduction Contributions under the terms of a Code Section 125 Plan.
- Medical care expenses that You or Your Dependents are reimbursed or reimbursable for through another health insurance plan, other insurance, or any other accident or health plan. However, if only a portion of a medical care expenses has been reimbursed elsewhere (e.g., because another health insurance plan imposes copayment or Deductible limitations), the HRA Account can reimburse the remaining portion if it otherwise meets the requirements.

Claim and Reimbursement Procedures

You must submit a claim for reimbursement of any eligible expense. If You, Your spouse, and/or Your Dependents are eligible for other coverage, You must include a copy of the Explanation of Benefits (EOB) from the other coverage as well as any EOB from this Plan. Only eligible expenses that have not been reimbursed, as shown on the EOB form, will be considered eligible for reimbursement.

You may submit eligible expenses for reimbursement at any time. While requests for reimbursement can be made at any time, to limit administrative expenses, **the Plan requires that any requests for reimbursement be for a minimum of $50**. Therefore, You will have to hold Your requests for reimbursement until You have at least $50 in eligible expenses. In addition, the amount reimbursed for any eligible expense will not exceed Your HRA balance at the time reimbursement is requested. However, in the event Your Plan coverage ends, You may submit eligible expenses totaling less than $50 to close out Your HRA.

To receive reimbursement for eligible expenses, You must submit a written claim form within 12 months of the date the expense was incurred and in accordance with the Plan's claim procedures. If You fail to do so, Your claim may be denied. In addition, any HRA payments that are unclaimed (e.g., uncashed checks) by the end of the year following the year in which the claim was incurred, will remain the property of the Plan.

Reimbursement applications must be accompanied by a signed statement verifying that the eligible expenses:

- Have not been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source (including an Health Care FSA, if applicable);
- For premiums paid for other coverage, have not been paid or are not eligible for payment on a pre-tax basis; and
- Have not been taken, nor intend to be taken, as a tax deduction.

Along with the form, You must provide any of the following, as applicable:

- An itemized bill from the service Provider that includes the name of the person incurring the charges, date of service, description of services, name of Provider, and amount of charge.
- An Explanation of Benefits (EOB) from any coverage (including any EOB from this Plan) when requesting reimbursement of the balance of charges for which coverage is available plus original receipts verifying payment.
- Proof of the amount and date paid when requesting reimbursement for other insurance premiums, such as a spouse's group health coverage premiums and verification that the premium was not paid or eligible for payment under an IRC Section 125 Plan. Additional documentation is also required for reimbursement of premiums under a qualified long-term care contract.
- A receipt and proof of purchase or rental for covered items (such as for crutches or wheelchairs).
- Any additional documentation requested by the Plan.

HRA benefits are intended to pay benefits only for medical care expenses not previously reimbursed or reimbursable elsewhere. If a medical care expense is payable or reimbursable from another source, that other source will pay or reimburse before payment or reimbursement from the HRA. However, if the eligible expense is covered by both the HRA and by a health care Flexible Spending Account (FSA), then the HRA is not available for reimbursement of that expense until after amounts available for reimbursement under the FSA have been exhausted.

Claim Submission

Please mail Your completed claim form and any required documentation to:

IBEW / NECA Sound and Communications Health and Welfare Trust
ATTN: HRA Claims Dept.
P.O. Box 5057
San Jose, CA 95150-5057

Note: The HRA is intended to qualify as a medical reimbursement plan under Code Sections 105 and 106 and associated regulations and as a health reimbursement arrangement as defined under IRS Notice 2002-45. Reimbursements under the HRA are intended to be eligible for exclusion from Your gross income under Code Section 105(b).

ADMINISTRATION OF THE PLAN AND CLAIM APPEAL PROCEDURES

The day-to-day administrative details of the IBEW / NECA Sound and Communications Health and Welfare Trust are provided by the Trust Administrative Office:

UNITED ADMINISTRATIVE SERVICES		
Mailing Address P.O. Box 5057 San Jose, CA 95150-5057	Phone Number: Toll Free Number: Fax Number:	(408) 288-4400 1-800-541-8059 (408) 288-4419
Street Address 1120 S. Bascom Ave. San Jose, CA 95128-3590	Business Hours: Email:	9:00 am to 4:30 pm Monday through Friday infos&c@uastpa.com

If You have any questions regarding the Plan, please contact United Administrative Services.

Claims (Other Than Life and Accidental Death and Dismemberment Insurance)

Claim forms must be completed in order to receive benefits. Claim forms may be obtained by calling or writing United Administrative Services or on the web at **www.soundcommbenefits.com**. After completing the claim form, mail or bring it, together with the itemized billing from the Provider to the Trust Administrative Office for processing.

Claims Will Be Paid In the Following Manner

1. Vision claims are processed and paid by:

   Vision Service Plan
   P.O. Box 997100
   Sacramento CA 95899-7100
   1-800-877-7195
   TDD/Hearing Impaired 1-800-735-2922

2. If You are using Postal Prescription Services (PPS) mail order prescription drug program, You must submit claim forms directly to Postal Prescription Services. Claim forms are available from the Trust Administrative Office or on the web at **www.soundcommbenefits.com**. Mail Your claim form to:

   Postal Prescription Services
   P.O. Box 2718
   Portland, OR 97208-2718

3. For United HealthCare Plan enrollees, present Your ID card to Your Provider at the time of service and make sure Your Provider bills United HealthCare directly.

4. For Kaiser Permanente enrollees, present Your ID card at Your Kaiser Permanente facility for services and prescription drugs.

Claim Filing Requirements

1. Time Requirements

a. Written notice of a claim must be given to the Trust Administrative Office as soon as reasonably possible.

b. Proof of claim for Hospital confinement must be given to the Trust Administrative Office within ninety (90) days after release from the Hospital.

c. Proof of claim for any other service, supply or treatment must be given to the Trust Administrative Office within ninety (90) days after the service or treatment.

d. If proof of any claim is not given within ninety (90) days, the claim will not be denied or reduced if the proof of the claim was given as soon as reasonably possible. **However, no claim will be paid if submitted to the Trust Administrative Office more than one year after date of service or treatment.**

"Proof" means proof satisfactory to the Board of Trustees.

2. Examination

a. The Board of Trustees, at the expense of the Trust, has the right to have You examined by a Provider, as often as it may require, whenever Your Illness or Injury is the basis of a claim.

b. The Board of Trustees has the right to require an autopsy, if not prohibited by law. A disputed Illness is a basis for this requirement.

Payment of Claims

All medical and dental claim payments will be paid to the Employee unless the claim has been assigned to a Hospital or Provider in writing or unless the Trust Administrative Office or Board of Trustees determines that the Employee is not legally able to complete a binding receipt or payment should be made to another person or entity.

If the Trust Administrative Office or Board of Trustees determines that the Employee is not legally able to receive such payment, the Board of Trustees may, at its option, pay the Hospital or Provider, Your estate or a relative. Any payment made under this option will discharge the Trust and Board of Trustees from further obligation for such payment.

The Board of Trustees reserves the right to allocate the Deductible amount to any Covered Charges and to apportion the benefits to You and to any assignees. Such actions will be binding on You and on Your assignees.

Return of Overpayment

If the Trust, Board of Trustees or Trust Administrative Office mistakenly pays a claim for which You are not entitled or makes a payment to a person, Hospital or Provider of services who is not entitled to the payment, or You do not make a required subrogation or reimbursement payment, the Board of Trustees has the right to recover the payment from the person paid or anyone else who benefited from it, including a Provider. The Board of Trustees' right to recover includes the right to deduct the amount paid by mistake or not paid via subrogation or reimbursement from future Covered Charges of You or any family member or from Your Reserve Dollar Bank Account.

Claims Appeal Procedure

If You have a claim concerning benefits provided by United HealthCare Plan and/or Kaiser Permanente Plan, Vision Service Plan or Standard Insurance Company, the claim should be filed with that organization in accordance with its claims appeal procedures.

If You have a claim concerning the denial of a short-term disability benefit, refer to the next section of the Benefit Booklet entitled Claims Appeal Procedure for Short-Term Disability Benefits on page 99.

If You have a claim that involves eligibility for coverage (such as insufficient money in Your Reserve Dollar Bank Account or a late self-payment), You may file an appeal pursuant to paragraph 3 on page 97.

If You have a claim for self-funded benefits that involves the Plan (such as a self-funded medical, prescription drug or dental benefit), the procedures outlined below apply.

1. Denial of a Claim by the Trust Administrative Office

a. The Trust Administrative Office is responsible for reviewing claims concerning eligibility and the Plan. If Your claim for a benefit under the Plan is denied, in whole or in part, You or Your Dependent will receive a written explanation from the Trust Administrative Office or the Trust's designee. The time in which a denial letter must be provided is based on the type of claim You have submitted.

i. **Concurrent Claim**. A concurrent claim is a claim that is reconsidered after initial approval of an ongoing course of treatment and results in a reduction or termination of benefits before the end of the approved course of treatment. An example is an Inpatient Hospital stay originally approved for five (5) days that is subsequently shortened to three (3) days. In the event of reconsideration, You must be notified so that You can appeal the decision and obtain a decision on appeal before the benefit is reduced or terminated.

ii. **Post Service Claim**. A post-service claim is a claim for payment after the care or treatment has been provided. An example is the extent to which a Provider's bill will be paid. The Trust Administrative Office will provide notice of the benefit determination (whether approved or adverse) within a reasonable period of time but no later than thirty (30) days after receipt of the claim. The time period may be extended up to an additional fifteen (15) days for matters beyond the Trust Administrative Office's control, but You will be notified of the extension before the end of the initial thirty (30) -day period. The notice will identify circumstances requiring the extension and the date by which the Trust Administrative Office expects to issue a decision. If the extension is necessary because You did not submit necessary information, the notice will describe the information required and give You an additional period of at least forty-five (45) days to furnish the information. In the event of an adverse benefit determination, You may appeal to the Board of Trustees, who will act on the appeal within the time limits set forth on pages 97-98.

2. Content of Initial Adverse Benefit Determination Notice

a. If Your claim is denied, the adverse benefit determination will be in writing and will provide:

i. The specific reason(s) for the adverse benefit determination;

ii. Reference to the specific Plan provision on which the adverse benefit determination is based;

iii. A description of any additional material or information necessary to perfect the claim and an explanation why such material or information is necessary;

iv. A description of the Plan's review procedure, the time limits applicable to such procedures, and Your right to bring a civil lawsuit for the benefit after an adverse determination by the Board of Trustees;

v. If the adverse benefit determination is based upon an internal rule, guideline, protocol or similar criterion, You will be notified of Your right to receive the document free of charge upon request; and

If the adverse benefit determination is based upon a decision involving Medical Necessity, Experimental treatment or other similar exclusions or limitations, You will be notified of Your right to receive a statement of the scientific or clinical judgment for the decision free of charge

3. Appeal of an Adverse Benefit Determination and Eligibility Determination

a. If You disagree with the initial adverse benefit or eligibility determination, You or Your authorized representative may file a written appeal within one hundred eighty (180) days after receiving the adverse benefit or eligibility determination. The written appeal must be mailed or delivered to:

IBEW / NECA Sound and Communications Health and Welfare Trust
ATTN: Appeals Board
c/o United Administrative Services

Mailing Address	*Street Address*
P.O. Box 5057	1120 S. Bascom Ave.
San Jose, CA 95150-5057	San Jose, CA 95128-3590

b. Upon written request, You will be provided free of charge reasonable access to and copies of all non-privileged documents, records and other information relevant to Your appeal. Whether a document, record or other information is relevant is determined in accordance with 29 CFR §2560.503-1(m)(8).

c. In conjunction with Your appeal, You or Your authorized representative may submit written comments, documents, records or other information relating to Your claim to the Board of Trustees.

d. If You or Your authorized representative request to appear at a hearing before the Board of Trustees at the time Your appeal is filed, You will be notified of the time, date and place of the hearing by regular mail at the return address shown on Your appeal.

e. You may be represented at the hearing before the Board of Trustees by an attorney or other authorized representative of Your choosing at Your cost and expense.

4. Decision by the Board of Trustees

a. Upon receipt of an appeal, the Board of Trustees will review the claim de novo (meaning without deference to the initial decision). The Board of Trustees will review all relevant information regardless of whether the information was previously submitted. If the appeal involves issues of medical judgment such as whether a particular treatment, drug or other procedure is Experimental, investigational or Medically Necessary, the Board of Trustees will consult a health care professional who has appropriate training and experience in the appropriate field of medicine. If the Board of Trustees consults a health care professional, he/she will be identified regardless of whether the Board of Trustees relies on his/her opinion. If the Board of Trustees consults a health care professional, he/she will be different than the health care professional previously consulted and will not be a subordinate of the health care professional previously consulted.

b. A decision will be made by the Board of Trustees at its next regularly scheduled meeting following receipt of the appeal unless the appeal is received less than thirty (30) days prior to the meeting. If

this is the case, the Board of Trustees will review the appeal no later than the date of the subsequent Board of Trustees' meeting. If, due to special circumstances, the Board of Trustees requires an extension of time to review the appeal, You will be notified in writing of the special circumstances necessitating the extension and when the decision will be made.

c. The decision of the Board of Trustees will be in writing and sent within five (5) days after the decision is reached.

d. If the Board of Trustees denies Your benefit appeal, the adverse benefit determination will include the following:

   i. The specific reason(s) for the adverse benefit determination;

   ii. Reference to the specific Plan provision on which the decision is based;

   iii. A statement that, upon written request, You will be provided free of charge reasonable access to and copies of all documents, records and other information relevant to Your claim. Whether a document, record or information is relevant is determined in accordance with 29 CFR §2560.503-1(m)(8);

   iv. A statement of Your right to bring a civil lawsuit for the benefit under ERISA;

   v. A statement that any internal rule, guideline, protocol or similar criterion used as a basis for the adverse benefit determination will be available free of charge upon written request; and

   vi. A statement that if the adverse benefit determination was based on Medical Necessity, Experimental treatment or other similar exclusions or limitations, You will be notified of Your right to receive a statement of the scientific or clinical judgment for the decision free of charge upon request.

e. If the Board of Trustees deny Your eligibility appeal, the decision will include the following:

   i. The specific reason for the decision;

   ii. Reference to the specific Plan provision on which the decision is based; and

   iii. A statement of Your right to bring a civil lawsuit under ERISA.

f. You are required to use the procedures set forth above before bringing a civil lawsuit for the benefit or eligibility under ERISA.

g. The Board of Trustees has the full and exclusive authority to administer the Plan, interpret the Plan, determine eligibility questions, determine eligibility for benefits, and resolve all questions arising in the administration, interpretation and application of the Plan. The Board of Trustees' authority includes, but is not limited to:

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

   ii. The right to establish and enforce rules and procedures for the administration of claims so long as the rules and procedures are consistent with ERISA;

   iii. The right to construe and interpret the Plan and determine eligibility for benefits including factual issues; and

   iv. The exercise of the aforementioned powers and authorities by the Board of Trustees will be given the fullest deference allowed by law.

Claims Appeal Procedure for Short-Term Disability Benefits

This Claims Appeal Procedure is applicable for the denial, reduction or termination of a short-term disability benefit.

1. Denial of a Short-Term Disability Benefit by the Trust Administrative Office

a. The Trust Administrative Office is responsible for reviewing an application for short-term disability benefits subject to the following time frame:

   i. If a claim for short-term disability benefits is denied by the Trust Administrative Office, You will be notified in writing. The written notice of denial will normally be provided within forty-five (45) days after receipt of a completed application for short-term disability benefits. If the Trust Administrative Office determines an extension of time is necessary to complete review of the short-term disability claim, because of matters beyond its control, the forty-five (45) day period may be extended for up to thirty (30) days provided the Trust Administrative Office notifies You of the extension of time during the initial forty-five (45) day period. If, prior to the end of the first thirty (30) day extension, the Trust Administrative Office determines that a further extension of time is necessary to complete review of the claim because of matters beyond its control, the thirty (30) -day extension period may be extended for up to an additional thirty (30) days provided that the Trust Administrative Office notifies You of the extension of time for processing the claim before the end of the first thirty (30) day extension period. If an extension of time is required by the Trust Administrative Office, You will be notified in writing and the notice will specify the reason(s) for the extension, the unresolved issue(s), if any, preventing a decision, additional information, if any, needed to resolve the issue(s) and the date a decision is expected.

2. Content of the Denial Notice from the Trust Administrative Office

a. If the Trust Administrative Office denies Your claim for short-term disability benefits, the denial notice will be in writing and will provide:

   i. The specific reason(s) for the decision.

   ii. Reference to the specific Plan provision on which the denial is based;

   iii. A description of any additional material or information necessary for You to perfect the claim and an explanation why such material or information is necessary;

   iv. A description of the Plan's review procedures, the time limits applicable to such procedures, Your right to relevant documents, records and information, the time limits applicable to such procedures and Your right to bring a civil lawsuit for the benefit after an adverse benefit determination by the Board of Trustees; and

   v. If the decision is based on an internal rule, guideline, protocol or other similar criterion, the internal rule, guideline, protocol or similar criterion will be described or provided to You free of charge upon request.

3. Appeal Procedure to the Board of Trustees

a. If a claim for short-term disability benefits has been denied or partially denied, You may appeal the denial to the Board of Trustees.

b. You or Your representatives have one hundred eighty (180) days following receipt of the denial notice from the Trust Administrative Office to file an appeal with the Board of Trustees. The appeal must be in writing and mailed or delivered as follows:

IBEW / NECA Sound and Communications Health and Welfare Trust
ATTN: Appeals Board
c/o United Administrative Services

Mailing Address	*Street Address*
P.O. Box 5057	1120 S. Bascom Ave.
San Jose, CA 95150-5057	San Jose, CA 95128-3590

c. Upon written request, You will be provided free of charge reasonable access to and copies of all documents, records and other information relevant to Your claim. Whether a document, record or other information is relevant to a claim will be determined in accordance with ERISA regulation 29 CFR §2560.503-1(m)(8).

d. In conjunction with Your appeal, You or Your representative may submit written comments, documents, records and other information relating to Your claim for short-term disability benefits to the Board of Trustees.

e. If You or Your authorized representative request to appear at the hearing before the Board of Trustees at the time Your appeal is filed, You will be notified of the time, date and place of the hearing by regular mail at the return address shown on Your request for review.

f. You may be represented at the hearing before the Board of Trustees by an attorney or other representative of Your choosing at Your cost and expense.

4. Decision by the Board of Trustees

a. Upon receipt of an appeal, the Board of Trustees will review the claim de novo (meaning without deference to the decision). The Board of Trustees will review all relevant information regardless of whether the information was submitted. If the appeal involves issues of medical judgment, the Board of Trustees will consult a health care professional who has appropriate training and experience in the appropriate field of medicine. If the Board of Trustees consults a medical or vocational expert, he/she will be identified regardless of whether the Board of Trustees rely on his/her opinion. If the Board of Trustees consults a health care professional, he/she will be different than the health care professional previously consulted and will not be a subordinate of the health care professional previously consulted.

b. A decision will be made by the Board of Trustees at their next regularly scheduled meeting following receipt of the appeal unless the appeal is received less than thirty (30) days prior to such meeting. If this is the case, the Board of Trustees will review the appeal not later than the date of the next Board of Trustees' meeting. If, due to special circumstances, the Board of Trustees requires an extension of time to review the appeal, You will be notified in writing of the special circumstances necessitating the extension and when the decision will be made.

c. The decision of the Board of Trustees will be in writing and sent within five (5) days after the decision is reached.

d. If the Board of Trustees deny Your appeal for short-term disability benefits, the decision will include the following:

   i. The specific reason(s) for the decision;

   ii. Reference to the specific Plan provision on which the denial is based;

   iii. A statement that, upon written request, You will be provided free of charge reasonable access to and copies of all documents, records and other information relevant to Your claim for Short-

Term Disability benefits. Whether a document, record or other information is relevant to a claim will be determined in accordance with 29 CFR §2560.503-1(m)(8);

iv. A statement of Your right to bring a lawsuit under §502(a) of ERISA; and

v. A statement that if the decision is based on an internal rule, guideline, protocol or other similar criterion, the internal rule, guideline, protocol or similar criterion will be described or provided to You free of charge upon request.

e. You are required to use the procedures set forth above before bringing a lawsuit for Short-Term Disability benefits or waiver of health and welfare premiums under ERISA.

f. The Board of Trustees has the full and exclusive authority to administer short-term disability claims, interpret the Plan as it relates to short-term disability benefits, determine eligibility for short-term disability benefits and resolve all questions arising in the administration, interpretation and application of the Plan that concerns short-term disability benefits. The Board of Trustees' authority includes, but is not limited to:

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

  ii. The right to establish and enforce rules and procedures for the administration of short-term disability benefits and any claim concerning short-term disability benefits so long as the rules and procedures are consistent with ERISA;

  iii. The right to construe and interpret the Plan as it relates to short-term disability benefits; and

  iv. The exercise of the aforementioned powers and authorities by the Board of Trustees will be given the fullest deference allowed by law.

COORDINATION OF MEDICAL BENEFITS (COB)

When a husband and wife or Domestic Partners both work, each may have a family health and welfare plan provided at his or her place of employment. If each spouse or Domestic Partner has a health and welfare plan for the other and/or for their children, questions arise as to which health and welfare plan should pay what amount in the event an Illness or Injury occurs. Coordination of benefits is a method for determining which health and welfare plan has primary responsibility to pay for benefits in a given situation and which health and welfare plan has secondary responsibility.

Definitions

The following definitions apply to this section of the Benefit Booklet:

Plan – means any of the following coverages which provide benefit payments or services to an Employee, Dependent or Domestic Partner for Medical Benefits:

1. Group or blanket insurance (except student accident insurance);
2. Group Blue Cross and/or BlueShield and other pre-payment coverage on a group basis, including HMOs;
3. Coverage under a labor-management trusted plan, a union welfare plan, an employer organization plan or an employee benefit plan;
4. Coverage under governmental plans, other than Medicaid, and any other coverage required or provided by law;
5. Group or individual "no fault" coverage; and
6. Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type Hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceed $100 per day.

Claimant – means the person for whom the claim for Medical Benefits is made.

Claim Period – means part or all of a calendar year during which the Employee, Dependent or Domestic Partner is covered by this Plan.

Covered Charge – means the Usual, Customary and Reasonable Charges for any Medically Necessary medical care, service or supply that is covered at least in part by any of the Plans involved during a Claim Period. Where a Plan provides Medical Benefits in the form of services or supplies rather than cash payments, the reasonable cash value of the service or supply during a Claim Period will also be considered a Covered Charge. The difference in cost of a private Hospital room and a semi-private Hospital room is not considered a Covered Charge unless the Employee's, Dependent's or Domestic Partner's stay in a private Hospital room is considered Medically Necessary by at least one of the Plans involved.

Coordination of Benefits

If an Employee, Dependent or Domestic Partner is covered by another Plan or Plans, the benefits under this Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, and then the other Plan(s) pays.

1. The Primary Plan (which is the Plan that pays benefits first) pays all the benefits that would be payable under its terms in the absence of this provision.

2. The Secondary Plan (which is the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefits and all other benefits paid by the Primary Plan will not exceed the greater of:

    a. 100% of the Covered Charge; or

    b. The amount of Covered Charge it would have paid had it been the Primary Plan.

If this Plan is the Secondary Plan, its financial obligation may be limited. If this Plan's payment obligation (as the Secondary Plan) for Covered Charges for an Illness, Injury or sickness would exceed $10,000, then it shall never pay more than the amount of money paid by the Primary Plan for the same Illness, Injury or sickness.

Order of Benefit Determination Rules

If the COB provision applies, the order of benefit determination rules set forth below control and determine which Plan is primary and which Plan(s) is secondary.

When another Plan does not have a COB provision, that Plan is the Primary Plan.

When another Plan does have a COB provision, the first of the following rules which apply determine which Plan is the Primary Plan:

1. If a Plan covers the Claimant as an Employee, member or non-Dependent, then that Plan is the Primary Plan;

2. If the Claimant is a Dependent child whose parents are not divorced or separated, then the Plan of the parent whose birthday is earlier in the calendar year will pay first except:

    a. If both parents' birthdays are on the same day, rule (4) below will apply.

    b. If another Plan does not include this COB rule based on the parents' birthdays, but instead has a COB rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits.

3. If the Claimant is a Dependent child whose parents are divorced or separated, the following rules will apply:

    a. The Plan which covers a child as a Dependent of the parent who by court decree must provide health coverage will be the Primary Plan; and

    b. When there is no court decree that requires a parent to provide health coverage to a Dependent child, the following rules will apply:

        i. When a parent who has custody of a child has not remarried, that parent's Plan will be the Primary Plan; and

        ii. When a parent who has custody of a child has remarried, then benefits will be determined by that parent's Plan first, by the stepparent's Plan second and by the Plan of the parent without custody third.

4. If none of the above rules apply, the Plan that has covered the Claimant for the longest period of time will be the Primary Plan except when:

a. One Plan covers the Claimant as a laid-off or retired Employee (or a Dependent of such Employee); and

b. The other Plan includes this COB rule for laid-off or retired Employees (or is issued by a state that requires this COB rule by law) then the Plan that covers the Claimant as other than a laid-off or retired Employee (or Dependent of such an Employee) will pay first.

Right to Receive and Release Necessary Information

In order to receive benefits, the Claimant must give the Plan any information that is needed to coordinate benefits. This Plan may release to or collect from any other person or organization any needed information about the Claimant.

Facility of Payment

Any payment made by another Plan may include an amount that should have been paid by this Plan. If so, this Plan may pay that amount to the Plan that made the payment. That amount will then be treated as though it was a benefit paid by this Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by this Plan is more than should have been paid under this COB section, this Plan may recover the excess from one or more of the following:

1. Any person or organization to whom payment was made;

2. Any Plan or other organization that should have made payment; or

3. The Claimant.

If You, Your Dependent or Domestic Partner have other health and welfare coverage and this Plan is secondary, You will receive faster claims service if You submit the claim to the Primary Plan first and attach a copy of its explanation of benefits form and an itemized bill showing the services received to Your claims submission to this Plan.

SUBROGATION AND REIMBURSEMENT OBLIGATION

Definitions

The following definitions apply to this section of the Benefit Booklet:

1. **Covered Person** – means an individual covered by this Plan as well as the estate, heirs, guardian and/or conservator of a Covered Person. Covered Person also includes any Trust established for the purpose of receiving Recovery Funds and/or paying future income, care or medical expenses to or for a Covered Person as the result of a Third Party Claim.

2. **Recovery Funds** – means any amount recovered by or for a Covered Person from a Third Party as the result of a Third Party Claim.

3. **Third Party Claim** – means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action by a Covered Person against a Third Party (or any right to assert the foregoing) alleging or claiming the Third Party may be responsible (from a liability and/or financial standpoint) for the Injury or Illness of a Covered Person for which Covered Charges are paid or may be paid by the Trust.

4. **Third Party** – means any individual or entity who may be fully or partially responsible (from a liability and/or financial standpoint) for the Injury or Illness of a Covered Person for which Covered Charges are paid or may be paid by the Trust. Third Party includes any insurer of such individual or entity and includes, but is not limited to, all types of liability insurance as well as other forms of insurance that may pay money to or on behalf of a Covered Person including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, personal injury protection coverage and worker's compensation coverage.

Subrogation Rights

Upon payment of Covered Charges for an Injury or Illness of a Covered Person that are related to a Third Party Claim, the Trust shall be subrogated to all a Covered Person's rights of recovery against the Third Party and the Covered Person shall do whatever is necessary to secure such rights and do nothing to prejudice them.

The Trust or its Board of Trustees may pursue the Third Party to recover the Covered Charges for an Injury or Illness that are paid or may be paid by the Trust that are related to the Third Party Claim in the Trust's name or in the name of a Covered Person. The Trust and its Board of Trustees are entitled to all subrogation rights and remedies of a Covered Person under common law and statutory law as well as under the Benefit Booklet.

Right of Recovery

In addition to the Trust's subrogation rights, the Trust and its Board of Trustees require the Covered Person and his/her attorney, if any, to protect the Trust's reimbursement rights. The following rules apply:

1. A Covered Person agrees to hold any Recovery Funds in a Trust or escrow account for the Trust up to the amount of Covered Charges the Trust paid or may pay for the Injury or Illness of a Covered Person that are related to the Third Party Claim. The Trust shall be paid first from the Recovery Funds.

2. A Covered Person grants the Trust an equitable lien and/or constructive Trust to all Recovery Funds up to the amount of Covered Charges the Trust paid or may pay for the Injury or Illness of a Covered Person that are related to the Third Party Claim. If the Covered Person is represented by an attorney, all Recovery Funds shall be deposited in the attorney's Trust account. No portion of

the Recovery Funds shall be paid to the Covered Person, the attorney or anyone other than the Trust until the Trust's right to reimbursement in paragraph (c) has been fully satisfied.

3. The Trust is entitled to a first priority recovery from the Recovery Funds for the full amount of Covered Charges it has paid or may pay for the Injury or Illness of a Covered Person that are related to the Third Party Claim. The repayment obligation exists regardless of whether: (i) a Covered Person has been made whole; (ii) the Third Party admits liability or asserts that a Covered Person is also at fault; (iii) a Covered Person only sought the recovery of non-economic damages; or (iv) a worker's compensation claim has been resolved through a disputed claims settlement where the parties agree the Injury or Illness is not work-related. The Board of Trustees reject the make whole, collateral source and common fund theories and the Trust's rights shall not be affected by similar doctrines or rules, whether established at common law or statute, that would reduce the Trust's right to full recovery under this Subrogation and Reimbursement Obligations section of the Benefit Booklet.

4. The Trust may require a Covered Person and his/her attorney to sign an agreement to abide by this Subrogation and Reimbursement Obligations section of the Benefit Booklet as a prerequisite to paying for Covered Charges.

5. A Covered Person and his/her attorney shall do nothing to prejudice the Trust's right of recovery under this Subrogation and Reimbursement Obligations section of the Benefit Booklet.

6. The Trust may, at the discretion of its Board of Trustees, suspend payment or deny payment of Covered Charges for an Injury or Illness of a Covered Person related to the Third Party Claim if a Covered Person and/or his/her attorney fail to cooperate and/or perform all acts required by this Subrogation and Reimbursement Obligations section of the Benefit Booklet or the Board of Trustees has a reasonable basis to believe a Covered Person will not honor all of his/her obligations under this Subrogation and Reimbursement Obligations section of the Benefit Booklet.

Additional Obligations of a Covered Person and Rights of the Trust and the Board of Trustees

In connection with the Trust's right to subrogation and reimbursement, a Covered Person shall do the following as applicable and agrees that the Trust and the Board of Trustees may do one or more of the following at the Board of Trustees' discretion:

1. If a Covered Person seeks payment for Covered Charges for an Injury or Illness for which there may be a Third Party Claim, a Covered Person shall notify the Trust Administrative Office of the potential Third Party Claim. A Covered Person has this responsibility even if the first request for payment of Covered Charges is a bill or invoice submitted to the Trust by a Provider.

2. Upon request from the Trust Administrative Office, a Covered Person shall provide the Trust Administrative Office with all available information relating to the potential Third Party Claim.

3. A Covered Person shall immediately disclose to the Trust Administrative Office all Recovery Funds and all settlements of any kind that have been obtained that are related to the Third Party Claim.

4. By accepting payment of Covered Charges relating to an Injury or Illness for which there may be a Third Party Claim, a Covered Person agrees that the Trust and its Board of Trustees have the right to intervene in any lawsuit, mediation or arbitration filed by or on behalf of a Covered Person seeking damages from a Third Party.

5. A Covered Person agrees that the Trust Administrative Office, Trust and/or Board of Trustees may notify any Third Party or Third Party's representative or insurer of the Trust's recovery rights set forth in this Subrogation and Reimbursement Obligations section of the Benefit Booklet.

6. This Subrogation and Reimbursement Obligations section of the Benefit Booklet applies regardless of whether a Covered Person's Injury or Illness for which there may be a Third Party Claim occurred before the Covered Person became enrolled in the Plan.

7. If any term, provision, agreement or condition this Subrogation and Reimbursement Obligations section of the Benefit Booklet is held by a Court to be invalid or unenforceable, the remainder of the section shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

8. The Board of Trustees has the authority to compromise subrogation and reimbursement claims on a case by case basis depending on the facts and circumstances.

LEGAL RIGHTS, NOTICES AND DISCLOSURES

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require a Provider obtain authorization from the plan or the issuer for prescribing length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If following a mastectomy You elect breast reconstruction in connection with such mastectomy, the following charges will be covered:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetric appearance;
- Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation between You and Your attending Physician;

This benefit is subject to the annual Deductible and copayments.

Qualified Medical Child Support Orders

The Board of Trustees will recognize and be bound by Qualified Medical Child Support Orders and National Medical Support Notices. You may contact the Trust Administrative Office to obtain, without charge, the procedure the Board of Trustees will follow when a Medical Child Support Order is received.

Certificate of Creditable Coverage

In accordance with the Health Insurance Portability and Accountability Act of 1996, the Trust Administrative Office will provide You with a written certificate concerning the length of health and welfare coverage under the Trust. This certificate will be provided to You at the following times:

1. When You cease to be covered under the Plan.
2. (Again) when You cease to be covered under COBRA.
3. If You request a certificate, within 24 months following termination of coverage.

Notice of Privacy Practices of the Trust and the Plan

This section of the Benefit Booklet describes how Protected Health Information about You may be used and disclosed and how You can get access to Your Protected Health Information. Please review this section carefully. If You have medical and prescription drug coverage or dental coverage through an insured plan, such as United HealthCare or Kaiser, that Plan may have its own privacy practices to protect Your medical information.

Policy of the Plan Regarding Your Protected Health Information

The Board of Trustees understands that Protected Health Information about You is personal and they are committed to protecting Protected Health Information about You.

This section of the Benefit Booklet describes the legal obligations of the Plan and Your legal rights regarding Your Protected Health Information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. Among other things, this section describes how Your Protected Health Information may be used or disclosed to carry out treatment, payment or health care operations, and for any other purposes that are permitted or required by law.

HIPAA only protects certain health information known as Protected Health Information. Generally, Protected Health Information is individually identifiable health information, including demographic information, collected from You or created or received by a health care Provider, a health care clearinghouse, a health plan or this Plan that relates to Your past, present or future physical or mental health or condition; the provisions of health care to You; or the past, present or future payment for Your health care.

This section of the Benefit Booklet will tell You about the ways the Plan may use and disclose Protected Health Information about You. This section also describes the Plan's obligations and Your rights regarding the use and disclosure of Your Protected Health Information. Your Physician or Provider may have different policies or notices regarding their use and disclosure of Your health information created in the Physician's office or clinic.

The Plan is required by law to:

1. Maintain the privacy of Your Protected Health Information;
2. Provide You with certain rights with respect to Your Protected Health Information;
3. Give You notice of the Plan's legal duties and privacy policies regarding Your Protected Health Information; and
4. Follow the terms of this section of the Benefit Booklet until modified.

How the Plan May Use and Disclose Health Information about You

Under the law, the Plan may use and disclose Your Protected Health Information under certain circumstances without Your permission. The following paragraphs describe different ways the Plan may use and disclose Your Protected Health Information. For each paragraph, the Benefit Booklet will explain what is meant and may present examples. Not every use or disclosure in a paragraph will be listed. However, all the ways the Plan is permitted to use or disclose Your Protected Health Information will fall within one of these paragraphs.

1. **To Make or Obtain Payment**

The Plan may use and disclose Protected Health Information about You to determine eligibility for benefits and to determine benefit responsibility under the Plan. For example, the Plan may tell Your Provider about Your medical history so it can determine whether a particular treatment is an Experimental or investigational service or Medically Necessary or to determine whether the Plan will cover the treatment. The Plan may share Your Protected Health Information with another entity to assist with the payment of health claims or with another health plan to coordinate benefit payments

2. **To Facilitate Treatment**

The Plan may use and disclose Your Protected Health Information to facilitate treatment or services by Providers, including coordination or management of health carrier related services. For example, the Plan may disclose Protected Health Information about You to Doctors who are treating You.

3. **To Coordinate Health Care Operations**

The Plan may use and disclose Your Protected Health Information to facilitate the administration of the Plan. These uses and disclosures are necessary to run the Plan. For example, health care operations include activities such as:

a. Quality assessment and improvement activities;

b. Activities designed to improve health or reduce health care costs;

c. Clinical guideline and protocol development, case management and care coordination;

d. Contacting Providers and participants with information about treatment alternatives and other related functions;

e. Health care professional competence or qualification review and performance evaluation;

f. Accreditation, certification, licensing and credentialing activities;

g. Underwriting, including premium rating and related functions to create, renew or replace health insurance or health benefits;

h. Review and auditing, including compliance reviews, medical reviews, legal services, fraud and abuse detection and compliance programs;

i. Business planning and development, including cost management and planning related to analyses and formulary development; and

j. Business management and general administration activities of the Plan, including customer service and resolution of appeals and grievances.

4. **When Required by Law**

The Plan will disclose Protected Health Information about You when required to do so by federal, state or local law. For example, the Plan may disclose Protected Health Information when required by a court order in a lawsuit such as a medical malpractice case.

5. **To Avert a Serious Threat to Health or Safety**

The Plan may use and disclose Protected Health Information about You when necessary to prevent a serious threat to Your health and safety or to the health and safety of the public or another person. Any disclosure will only be made to someone able to help prevent the threat. For example, the Plan may disclose Protected Health Information about You in a proceeding regarding the licensure of a Doctor.

6. Military and Veterans

If You are a member of the armed forces, the Plan may release Protected Health Information about You as required by military command authorities. The Plan may also release Protected Health Information about foreign military personnel to the appropriate foreign military authority.

7. **For Treatment Alternatives**

The Plan may use and disclose Your Protected Health Information to tell You about or recommend possible treatment options or alternatives that may be of interest to You.

8. **For Distribution of Health-Related Benefits and Services**

The Plan may use and disclose Your Protected Health Information to provide information on health-related benefits and services that may be of interest to You.

9. **For Disclosure to the Board of Trustees**

The Plan may disclose Your Protected Health Information to another health plan maintained by the IBEW / NECA Sound and Communications Health and Welfare Trust or to the Board of Trustees for Plan administration functions performed by the Board of Trustees on behalf of the Plan. In addition, the Plan may provide summary health information to the Board of Trustees so that the Board of Trustees may solicit premium bids from health insurers or modify, amend or terminate the Plan. The Plan may also disclose to the Board of Trustees information whether You are participating in the Plan. Your Protected Health Information cannot be used for employment purposes without Your specific authorization.

10. **A Family Member or Close Personal Friend Involved in Your Health Care**

The Plan may disclose Your Protected Health Information to a family member or close personal friend. Disclosure of Your Protected Health Information will be determined based on how involved the person is in Your health care or payment of Your health care claims. For example, the Plan will normally provide information to a family member confirming eligibility for health coverage or if a claim was paid but not the specific treatment or diagnosis provided or the reason the Provider was consulted. The Plan may release Protected Health Information to parents or guardians, if allowed by law. If You are not present or able to agree to these disclosures of Your Protected Health Information, the Plan, through the Trust Administrative Office or Board of Trustees, may use professional judgment to determine whether the disclosure is in Your best interest. If You do not want Your Protected Health Information disclosed to a family member or close personal friend as outlined in this paragraph, You must notify the Plan as described in the Right to Request Restrictions on page 115.

11. **Personal Representative**

The Plan may disclose Your Protected Health Information to individuals authorized by You, or to an individual designated as Your personal representative, attorney-in-fact, etc., so long as You provide written notice/authorization and any supporting documents (for example, power of attorney). Even if

You designate a personal representative, federal law permits the Plan to elect not to treat the person as Your personal representative if the Plan has a reasonable belief that:

a. You have been, or may be, subject to domestic violence, abuse or neglect by such person;
b. Treating such a person as Your personal representative could endanger You; or

c. Plan representatives determine, in their professional judgment, that it is not in Your best interest to treat the person as Your personal representative.

12. **Business Associates**

Business associates perform various services for the Plan. For example, the Trust Administrative Office handles many functions in connection with the operation of the Plan. To perform these functions, or provide the services, the Plan's business associates may receive, create, maintain, use or disclose Your Protected Health Information, but only after agreeing, in writing, to appropriate safeguards concerning Your Protected Health Information. Business associates are subject to the HIPAA privacy and security provisions with respect to Your Protected Health Information.

13. **Other Covered Entities**

The Plan may use or disclose Your Protected Health Information to assist Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose Your Protected Health Information to a Provider when needed by the Provider to render treatment to You or the Plan may disclose Protected Health Information to another covered entity to conduct health care operations in the area of quality assurance.

14. **To Conduct Health Oversight Activities**

The Plan may disclose Your Protected Health Information to a health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

15. **Legal Proceedings**

If You are involved in a lawsuit or a dispute, the Plan may disclose Your Protected Health Information in response to a court or administrative order. The Plan may also disclose Your Protected Health Information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell You about the request or to obtain an order protecting the information requested.

16. **Law Enforcement**

Under certain conditions, the Plan may disclose Your Protected Health Information to law enforcement officials. Some of the reasons for such a disclosure include, but are not limited to:

a. It is required by law or some other legal process;

b. Locate or identify a suspect, fugitive, material witness or missing person; or

c. It is necessary to provide evidence of a crime that occurred.

17. **National Security and Intelligence**

In certain circumstances, federal regulations require the Plan to disclose Your Protected Health Information to facilitate specified government functions related to national security, intelligence activities and other national security activities authorized by law.

18. **Abuse or Neglect**

The Plan may disclose Your Protected Health Information to a governmental entity that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity authorized to receive such information Your Protected Health Information if the Plan believes that You have been a victim of abuse, neglect or domestic violence.

19. **Research**

The Plan may disclose Your Protected Health Information to researchers when:

a. The individual identifiers have been removed; or

b. When the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approved the research.

20. **Inmates**

If You are an inmate in a correctional institution, the Plan may disclose Your Protected Health Information to the correctional institution or to a law enforcement official for:

a. The institution to provide health care to You;

b. Your health and safety and the health and safety of others; or

c. The safety and security of the correctional institution.

The following Protected Health Information will not be disclosed without specific written authorization from You:

- most uses and disclosures of psychotherapy notes (if recorded by a covered entity);
- uses and disclosures of Protected Health Information for marketing purposes, including subsidized treatment communications; and
- disclosures that constitute a sale of Protected Health Information.

If You have paid for services out of pocket, in full, and You request that the healthcare Provider not disclose Protected Health Information related solely to those services to the IBEW/NECA Sound and Communications Health and Welfare Plan, the healthcare provider must accommodate Your request, except where the healthcare provider is required by law to make a disclosure (45 C.F.R. §164.520(b)(1)(iv)(A)).

In regards to underwriting, premium rating, or similar activities, the Plan is prohibited from using or disclosing Protected Health Information that is genetic information about an individual.

21. **Coroners, Medical Examiners, Funeral Directors and Organ Donation**

The Plan may disclose Your Protected Health Information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The Plan may also disclose, as authorized by law, information to funeral directors so they may carry out their duties. If You are an organ donor, the Plan may disclose Protected Health Information to organizations that handle organ, eye or tissue donation and transplantation.

22. **Workers' Compensation**

The Plan may release Your Protected Health Information to the extent necessary to comply with workers' compensation laws and similar programs that provide benefits for work-related Injuries or Illnesses.

23. **Disclosures to the Secretary of the U.S. Department of Health and Human Services**

The Plan is required to disclose Your Protected Health Information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

24. **Public Health Risks**

The Plan may disclose Your Protected Health Information for public health actions. These actions generally include the following:

a. To prevent or control disease, Injury or disability;

b. To report births and deaths;

c. To report child abuse or neglect;

d. To report reactions to medications or problems with products;

e. To notify people of recalls of products they may be using;

f. To notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition; and

g. To notify the appropriate governmental authority if the Plan believes that a person has been the victim of abuse, neglect, or domestic violence. The Plan will only make this disclosure if You agree, or when required or authorized by law.

25. **Disclosures to You**

Upon Your request, the Plan is required to disclose to You the portion of Your Protected Health Information that contains medical records, billing records and other records used to make decisions regarding Your health care benefits. The Plan is also required, when requested, to provide You with an accounting of most disclosures of Your Protected Health Information if the disclosure was for reasons other than for payment, treatment, or health care operations and if the Protected Health Information was not disclosed pursuant to Your authorization.

26. **Disclosures to the Centers for Medicaid and Medicare Services**

The Plan may disclose Your Protected Health Information, as permitted by federal regulations, to the Centers for Medicaid and Medicare services, in order to comply with mandatory Medicare

coordination of benefit requirements. The Plan may share required data, including health information, with the Centers for Medicaid and Medicare Services and state Medicaid agencies.

Authorization to Use or Disclose Protected Health Information

Other than as stated above, the Plan will not disclose Your Protected Health Information without Your written authorization. If You authorize the Plan to use or disclose Your Protected Health Information, You may revoke that authorization in writing at any time.

Minimum Necessary Disclosure of Health Information

The amount of Protected Health Information the Plan will use or disclose will be limited to the "minimum necessary" as defined in the HIPAA Privacy Rule.

Potential Impact of State Laws

The HIPAA Privacy Rule generally does not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which the Plan will be required to operate. For example, the Plan will follow more stringent state privacy laws that relate to use and disclosure of Protected Health Information concerning HIV or AIDS, mental health, Substance Abuse, genetic testing, reproduction rights, and so on.

Your Rights with Respect to Your Protected Health Information

You have the following rights regarding Your Protected Health Information that the Plan maintains:

1. **Right to Request Restrictions**

   You have the right to request restrictions or limitations on the Protected Health Information the Plan uses or discloses about You for treatment, payment or health care operations. You also have the right to request a limit on the Plan's disclosure of Your Protected Health Information to someone involved in Your care or the payment for Your care such as a family member or friend. For example, You could ask that the Plan not use or disclose information about a surgery You had.

   Except as provided in the next paragraph, the Plan is not required to agree to Your request. However, if the Plan does agree to the request, it will honor the restriction until You revoke it or the Plan notifies You.

   The Plan will comply with any restriction request if: except as otherwise required by law, the disclosure is to the health Plan for purposes of carrying out payment or health care operations (and is not for the purpose of carrying out treatment); and the Protected Health Information pertains solely to a health care item or service for which the Provider involved has been paid in full.

   To request restrictions, You must make Your request in writing to the Client Service Representative for the Trust at the address on page 117. In Your written request, You must tell the Plan:

   a. What Protected Health Information You want to limit;

   b. Whether You want to limit the Plan's use, disclosure or both; and

   c. To whom You want the limits to apply, for example, non-disclosure to Your spouse.

2. **Right to Receive Confidential Communications**

You have the right to request that the Plan communicate with You about health matters in a manner other than by mail or at an alternative location if You feel the disclosure of Your Protected Health Information could endanger You. For example, You may ask that the Plan communicate with You only at a certain post office box, telephone number or by email.

To request confidential communications, You must make Your request in writing to the Client Service Representative for the Trust at the address on page 117. The Plan will not ask You the reason for the request. The Plan will attempt to honor all reasonable requests. Your written request must specify how or where You wish to receive confidential communications.

3. **Right to Inspect and Request a Copy of Your Protected Health Information**

You have the right to inspect and request a copy of Your Protected Health Information. A request to inspect and for a copy of records containing Your Protected Health Information must be made in writing to the Client Service Representative for the Trust at the address on page 117. If You request a copy of Your Protected Health Information, the Plan may charge a reasonable fee for copying, assembling and postage.

4. **Right to Amend Your Protected Health Information**

If You believe that Your Protected Health Information records are inaccurate or incomplete, You may request that the Plan amend its records. The request may be made as long as the Protected Health Information is maintained by the Plan.

A request for an amendment of Your Protected Health Information records must be made in writing to the Client Service Representative for the Trust at the address on page 117.

The Plan may deny Your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny Your request if You ask the Plan to amend Protected Health Information that is not part of the Protected Health Information kept by or for the Plan; was not created by the Plan, unless the person or entity that created the Protected Health Information is no longer available to make the amendment; is not part of the Protected Health Information that You would be permitted to inspect and copy; or is already accurate and complete. If the Plan denies Your request, You have the right to file a statement of disagreement with the Plan and any future disclosures of the disputed Protected Health Information will include Your statement.

5. **Right to an Accounting of Disclosures**

You have the right to request an accounting of certain disclosures of Your Protected Health Information. The accounting will not include: disclosures for the purpose of treatment, payment or health care operations; disclosures made to You; disclosures made pursuant to Your authorization; disclosures made to friends or family members in Your presence or because of an emergency; disclosures for national security purposes; and disclosures incidental to otherwise permissible disclosures.

The request for an accounting must be made in writing to the Client Service Representative for the Trust at the address on page 117. The accounting request should specify the time period for which You are requesting the accounting. Accounting requests may not be made for a period of time going back more than six years. The Plan will provide the first accounting You request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform You of the fee in advance.

6. **Right to be Notified of a Breach**

   You have the right to be notified in the event that the Plan, or a business associate, discovers a breach of Your unsecured Protected Health Information.

7. **Right to a Paper Copy of the Plan's Privacy Notice**

   You have a right to a paper copy of the Plan's Privacy Practices. You may ask the Plan to give You a copy of this notice at any time. To receive a paper copy, please contact the Client Service Representative for the Trust at the address on page 117.

Duties of the Plan

The Plan is required by law to maintain the privacy of Your Protected Health Information as set forth in this section and to provide this information to You. The Plan is required to abide by the terms of this section, which may be amended from time to time. The Plan reserves the right to change the terms of this section and to make the new provisions effective for all Protected Health Information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the section and will provide a copy of the revised section to You within sixty (60) days of the change.

Complaints

If You believe that Your privacy rights have been violated, You may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, You should notify the HIPAA Client Service Representative for the Trust, in writing, at the address on page 117. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with the Plan.

Contact Person

The Plan has designated the Trust's Client Service Representative to answer all questions and respond to all issues regarding this section and Your privacy rights. You may contact this person at:

IBEW / NECA Sound and Communications Health and Welfare Trust
Client Service Representative
c/o United Administrative Services

Mailing Address
P.O. Box 5057
San Jose, CA 95150-5057

Street Address
1120 S. Bascom Ave.
San Jose, CA 95128-3590

Phone: (408) 288-4400
Toll-Free: 1-800-541-8059

If You have any questions regarding this section, please contact a Client Service Representative of the Trust.

Disclosure of Protected Health Information to the Board of Trustees

The Trust and the Plan may disclose Your Protected Health Information to the Board of Trustees subject to the terms and conditions set forth below:

1. **Disclosure of Protected Health Information to the Board of Trustees**

   Unless otherwise permitted by law, the Trust, Plan and any health insurance issuer or business associate providing services to the Trust and/or Plan will only disclose Your Protected Health

Information to the Board of Trustees to the extent necessary to permit the Board of Trustees to carry out Plan administrative functions consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations. Any disclosure to or use by the Board of Trustees of Your Protected Health Information will be subject to and consistent with the provisions of Sections 2 and 3 below.

2. **Board of Trustees' Obligations Regarding Protected Health Information**.

The Board of Trustees will:

a. **Prohibit Unauthorized Use or Disclosure of Health Information.** Neither use nor disclose Your Protected Health Information except as permitted by the Plan Document and Benefit Booklet for the Plan as amended from time to time or required by law.

b. **Subcontractors and Agents.** Ensure that any third party or agent to whom the Board of Trustees provides Your Protected Health Information received from the Trust and/or Plan agrees to the restrictions and conditions in the Plan Document and Benefit Booklet for the Plan, including this section, with respect to Your Protected Health Information.

c. **Permitted Purposes.** Neither use nor disclose Your Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by the Board of Trustees.

d. **Reporting.** Report to the Plan any use or disclosure of Your Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan Document and Benefit Booklet for the Plan promptly upon learning of such inconsistent use or disclosure.

e. **Access to Your Health Information.** Make Your Protected Health Information available to You in accordance with 45 C.F.R. § 164.524.

f. **Amendment of Health Information.** Make Your Protected Health Information available for amendment and, upon request, amend Your Protected Health Information in accordance with 45 C.F.R. § 164.526.

g. **Accounting of Health Information Disclosures.** Track disclosures of Your Protected Health Information so that an accounting of disclosures can be made to You in accordance with 45 C.F.R. § 164.528.

h. **Disclosure to Governmental Agencies.** Make the Trust and Plan's internal practices, books and records relating to the use and disclosure of Your Protected Health Information available to the US Department of Health and Human Services to determine compliance with 45 C.F.R. §§ 160-164.

i. **Return or Destruction of Health Information.** When Your Protected Health Information is no longer needed for the purpose for which use or disclosure was made, each Trustee must, if feasible, return to the Plan, or destroy, all Protected Health Information that he received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the Protected Health Information. If return or destruction is not feasible, the Trustee agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

j. **Minimum Necessary Requests.** The Board of Trustees will use its best efforts to request only the minimum necessary type and amount of Your Protected Health Information to carry out the functions for which the information is requested.

3. **Board of Trustees' Obligations Regarding Electronic Health Information**

The Board of Trustees agrees that if it creates, receives, maintains or transmits any electronic health information (other than enrollment/disenrollment information and summary health information that are not subject to these restrictions) on behalf of the Trust and/or Plan concerning You, it will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic health information.

The Board of Trustees will ensure that any third party or agents to whom it provides such electronic health information agree to implement reasonable and appropriate security measures to protect this information.

The Board of Trustees will report to the Plan any security incident, as defined in 45 C.F.R.§ 164.304, that results in unauthorized access, use, disclosure, modification or destruction of the Trust's or Plan's electronic health information of which it becomes aware within a reasonable period of time. The Board of Trustees will also report to the Trust and Plan any other security incident on an aggregate basis every year, or more frequently based upon the Trust or Plan's written request.

4. **Adequate Separation Between the Board of Trustees, the Trust and the Plan**

The Board of Trustees represents that adequate separation exists between the Trust and the Plan and the Board of Trustees so that Protected Health Information will be used only for Plan administration purposes.

The following persons or organizations that have a contractual arrangement with the Trust or Board of Trustees may receive Your Protected Health Information relating to payment, health care operations or other matters pertaining to the Plan:

a. Employees of United Administrative Services; and

b. Business associates of the Trust and Plan and business associates' employees, officers, directors, agents and subcontractors provided the business associate has signed a business associate agreement.

The persons and organizations identified above will have access to Your Protected Health Information only to perform Plan administration functions. The persons and organizations identified above will be subject to disciplinary action and sanctions, including termination of their contracts, for any use or disclosure of Your Protected Health Information that violates the business associate agreement.

The Board of Trustees will ensure that the provisions of this section 4 are supported by reasonable and appropriate security measures to the extent that the persons or organizations identified above have access to Your electronic health information.

5. **Reports of Non-Compliance**

Anyone who suspects an improper use or disclosure of his/her Protected Health Information may report the occurrence to the Plan's representative at the following address and telephone number:

IBEW / NECA Sound and Communications Health and Welfare Trust
Client Service Representative
c/o United Administrative Services
P.O. Box 5057
San Jose, CA 95150-5057
Phone: (408) 288-4400
Toll-Free: 1-800-541-8059

6. **Making Requests**

   Requests to inspect and copy, to correct or amend and for an accounting of Your Protected Health Information should be made in writing to:

   IBEW / NECA Sound and Communications Health and Welfare Trust
   Client Service Representative
   c/o United Administrative Services
   P.O. Box 5057
   San Jose, CA 95150-5057

7. **Certificate by the Board of Trustees**

   The Trust, the Plan, any health insurance issuer and HMO will disclose Protected Health Information to the Board of Trustees only upon the receipt of a certificate from the Board of Trustees that the Plan Document has been amended to incorporate the provisions of 45 C.F.R. § 164.504(f)(2)(ii) and that the Board of Trustees agrees to the conditions of disclosure set forth in Section 2 on page 118.

Disclosure of Grandfathered Health Plan Status

The information in this section is required by the federal Patient Protection and Affordable Care Act (the Affordable Care Act).

The Board of Trustees believes the Plan is a grandfathered health plan under the Affordable Care Act.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, a requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Administrative Office whose address and telephone number are listed on page 2. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor, at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. The website has a table summarizing which protections do and do not apply to a grandfathered health plan.

SUMMARY PLAN DESCRIPTION

This summary is a general explanation of certain terms of the Plan and other legal instruments, and is not intended to modify or change them in any manner. The rights and duties of all persons connected with the Plan are set forth in those instruments, which may be inspected at the Trust Administrative Office.

Name of Plan

IBEW / NECA Sound and Communications Health and Welfare Plan

Effective Date

January 1, 2013

Plan Sponsor and Plan Administrator

This Plan is sponsored and administered by:

Joint Labor-Management Board of Trustees of the
IBEW / NECA Sound and Communications Health and Welfare Plan
c/o United Administrative Services

Mailing Address	*Street Address*
P.O. Box 5057	1120 S. Bascom Ave.
San Jose, CA 95150-5057	San Jose, CA 95128-3590

Phone: (408) 288-4400
Toll-Free: 1-800-541-8059

Employer and Plan Identification Numbers

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

- Employer Identification Number – 77-0234638
- Plan Identification Number – 501

Type of Plan

This Plan is a health and welfare benefit plan.

Trust Administrative Office

This Plan is administered by the Board of Trustees of the IBEW / NECA Sound and Communications Health and Welfare Plan, with the assistance of United Administrative Services, a contract administration organization whose address and telephone number are:

United Administrative Services

Mailing Address	*Street Address*
P.O. Box 5057	1120 S. Bascom Ave.
San Jose, CA 95150-5057	San Jose, CA 95128-3590

Phone: (408) 288-4400
Toll-Free: 1-800-541-8059

Agent for Legal Service

Joint Board of Trustees
c/o United Administrative Services
1120 S. Bascom Ave.
San Jose, CA 95128-3590

Service of legal process may also be made upon any member of the Board of Trustees.

Board of Trustees

__Labor Trustees__

Gerald Pfeiffer
I.B.E.W. Local Union No. 332
2125 Canoas Garden Ave., Ste 100
San Jose, CA 95125-1393

Timothy J. Donovan
I.B.E.W. Local Union No. 6
55 Fillmore Street
San Francisco, CA 94117

Dan Chivello
I.B.E.W. Local Union No. 595
6250 Village Parkway
Dublin, CA 94568

Scott Stephan
I.B.E.W. Local Union No. 302
1875 Arnold Drive
Martinez, CA 94553

__Management Trustees__

Doug Lung
Santa Clara Valley Chapter NECA
P. O. Box 28899
San Jose, CA 95159

Rick Jensen
JM Electric
400 Griffin Street
Salinas, CA 93901

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

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 Employers will make the required Contributions to the IBEW / NECA Sound and Communications Health and Welfare Trust Fund for the purpose of enabling the Employees working under the Collective Bargaining Agreements to receive the benefits provided by the Trust Fund. The Contribution rate is specified in the Collective Bargaining Agreements. Copies of the Collective Bargaining Agreements can be obtained from the participating I.B.E.W. Local Unions.

A complete list of Employers contributing to the IBEW / NECA Sound and Communications Health and Welfare Trust Fund may be obtained upon written request to the Board of Trustees and is available for examination during regular office hours at the Trust Administrative Office.

Plan Benefits

This Plan provides short-term disability benefits, accidental death and dismemberment benefits and life insurance benefits for Employees only, and medical, prescription, dental, and vision benefits for Employees and Dependents.

Your coverage will depend on the Medical and Prescription Drug plan option You select.

Benefits, Eligibility and Termination of Eligibility

This Benefit Booklet describes benefits, eligibility and termination of eligibility requirements under the Plan. If at any time You are unable to locate Your Benefit Booklet, an additional copy may be obtained from the Trust Administrative Office:

United Administrative Services
1120 S. Bascom Ave.
San Jose, CA 95128-3590
Phone: (408) 288-4400
Toll-Free: 1-800-541-8059

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) Agreements, the amount that is specified by the Board of Trustees. Also, self-payments by Employees and Dependents are permitted as outlined in the COBRA section starting on page 16. The amount of self-payments is fixed from time to time by the Board of Trustees.

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 Plan and whether the benefit is payable under an insurance policy) are set forth below.

Medical, Dental, and Short-Term Disability Benefits under the Plan

Claims arising from the Plan for medical and dental benefits for Employees and Dependents and the Short-Term Disability benefits for Employees are paid directly from Trust assets.

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 Indemnity PPO Plan for Medical Benefits. The Trust is responsible for paying claims submitted by Providers, clinics and Hospitals. The Preferred Provider Organization is responsible for the administration of contracts with Providers, clinics and Hospitals. The Preferred Provider Organization is:

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, CA 91367

Utilization Review, Personal Case Management and Disease Management Organization

The Trust has entered into a contract with a company that provides Utilization Review, personal case management and disease management services for Employees and Dependents enrolled in the Plan for Medical Coverage. The Trust pays the company a fee for the services it provides. The company providing these services is:

Anthem Blue Cross
21555 Oxnard Street
Woodland Hills, CA 91367

Health Maintenance Organizations / Alternate Health Plans

Employees and Dependents have the option of selecting medical and prescription drug coverage from a health maintenance organization (United HealthCare or Kaiser Permanente). The medical and prescription drug benefits are insured and provided under contracts between the Trust and United HealthCare Plan and the Kaiser Permanente Foundation Health Plan. United HealthCare Plan and the Kaiser Permanente Foundation Health Plan are responsible for administering their plans and paying the claims.

Kaiser Permanente Foundation Health Plan, Inc.
Northern California Region
1950 Franklin Street
Oakland, CA 94612

United HealthCare
5995 Plaza Drive
Cypress, CA 90630

Prescription Drug Program

The Plan's prescription drug program for Employees and Dependents is provided by RESTAT, LLC. The Trust is responsible for paying the prescription drug claims. A fee is paid to RESTAT, LLC for administering the prescription drug program.

RESTAT, LLC
11900 West Lake Park Drive
Milwaukee, WI 53224

Mail Order Prescription Drug Program

The mail order prescription drug program for Employees and Dependents is provided by Postal Prescription Services (PPS). The Trust is responsible for paying the mail order prescription drug claims. A fee is paid to Postal Prescription Services for administering the program.

Postal Prescription Services
P.O. Box 2718
Portland, OR 97208

Mental Health Benefits

Mental Health benefits for Employees and Dependents enrolled in the Self-Funded Medical Indemnity PPO Plan or the United HealthCare Plan are provided by Optum Health. The benefits are provided and insured under a group contract between the Trust and Optum Health. The Trust pays the company a premium for the benefits it provides. Optum Health is responsible for administering the program and paying the claims.

Optum Health
425 Market Street
12th Floor
San Francisco, CA 94105

Substance Abuse Benefits

Substance Abuse benefits for Employees and Dependents enrolled in the Self-Funded Medical Indemnity PPO Plan or the United HealthCare Plan are provided by Optum Health. The benefits are provided and insured under a group contract between the Trust and Optum Health. The Trust pays the company a premium for the benefits it provides. Optum Health is responsible for administering the program and paying the claims.

Optum Health
425 Market Street
12th Floor
San Francisco, CA 94105

Member Assistance Program

The member assistance program benefits for Employees and Dependents are provided by Optum Health. The benefits are provided under a group contract between the Trust and Optum Health. The Trust pays the company a fee for the benefits it provides. Optum Health is responsible for administering the program and paying the benefits.

Optum Health
425 Market Street
12th Floor
San Francisco, CA 94105

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 program.

Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899
1-800-877-7195

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 contracts between the Trust and Standard Insurance Company. Standard Insurance Company is responsible for administering the programs and paying the claims.

Standard Insurance Company
900 SW 5th Ave.
Portland, OR 97204
1-800-628-8600

Dental Plan

The Trust has entered into a contract with a Preferred Provider Dental Organization that can be used by Employees and Dependents enrolled in the Plan for Dental Benefits. The Trust is responsible for paying claims submitted by Dental Providers. The Preferred Provider Dental Organization is responsible for the administration of contracts with Dental Providers. The Preferred Provider Dental Organization is:

First Dental Health, Inc.
7220 Trade Street
Suite 350
San Diego, CA 92121
1-800-334-7244

Plan Year

The Plan Year begins each January 1 and ends the following December 31.

Plan Termination

Should this Plan terminate for any reason, all money and assets remaining in the Plan, after the payment of expenses, will be used for the continuance of the benefits provided by the then existing benefit plans, until such money and assets have been exhausted, unless some other disposition is required in regulations adopted by the U.S. Department of Labor.

Liability of Third Parties and the Board of Trustees

No Employer has any liability, directly or indirectly, to provide the benefits established by this Plan beyond the obligation to make Contributions required by its Collective Bargaining Agreement or Category 2 (Subscription) Agreement. Likewise, there will be no liability upon the Board of Trustees, individually or collectively, or upon the chapters of the National Electrical Contractors Association (NECA) or I.B.E.W. Local Unions to provide the benefits established by this Plan if assets are not available to make such benefit payments.

ERISA Statement of Rights

As a participant in the IBEW / NECA Sound and Communications Health and Welfare Trust, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

1. Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor.

2. Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. A reasonable charge may be made for the copies.

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

4. Continue health care coverage for Yourself, spouse, Domestic Partner, 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 starting on page 16 for the rules governing Your COBRA Continuation Coverage rights.

5. Reduction or elimination of exclusionary periods of coverage for Preexisting Conditions under Your group health Plan if You have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from Your group health Plan or health insurance issuer when You lose coverage under the Plan, when Your COBRA Continuation Coverage ceases and if You request a certificate up to 24 months after losing coverage. Without evidence of creditable coverage, You may be subject to a Preexisting Condition exclusion for six months after Your enrollment date in Your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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. If Your claim for a welfare benefit is denied in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider Your claim. Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request

materials from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If You have a claim for benefits that is denied or ignored, in whole or in part, You may file suit in a state or federal court. In addition, if You disagree with the Plan's decision or lack of a decision 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 Trust Administrative Office. If You have any questions about this statement, about Your rights under ERISA, or about Your rights under the Health Insurance Portability and Accountability Act of 1996 or if You need assistance in obtaining documents from the Plan administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory. Alternatively, You may obtain assistance by calling the Employee Benefits Security Administration's toll-free number 1-866-444-3272 or writing to the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave. 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 at 1-866-444-3272. You may also find assistance for Your questions and a list of Employee Benefits Security Administration field offices at: www.dol.gov/ebsa.

DEFINITION OF TERMS

Accidental Bodily Injury – An Injury caused by an external force or element such as a blow or fall that requires immediate medical attention.

AD&D Insurance – Accidental death and dismemberment insurance provided under a 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 subsequently made.

Benefit Period – Claims incurred for services rendered January through December of a calendar year. A Benefit Period is established and begins when You have incurred, during a calendar year, Covered Charges that exceed the Deductible. All Covered Charges 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 IBEW / NECA Sound and Communications Health and Welfare Plan and their successors.

Category 1 (bargaining unit) Employee – An employee who works under a Collective Bargaining Agreement between an Employer and certain Local Unions of the I.B.E.W. (6, 100, 180, 234, 302, 332, 340, 551, 591, 595, 617 or 684).

Category 2 (non-bargaining) Employee – An employee who is not a member of any Collective Bargaining Unit represented by a Union and who is a full-time employee of a Contributing Employer, a NECA chapter, or a Union.

Category 2 (Subscription) Agreement – A written agreement between the Board of Trustees or the Trust and a Contributing Employer that allows the Contributing Employer to provide health and welfare benefits to or for its Employees who are not covered by a Collective Bargaining Agreement.

Claimant – An individual asserting a claim for life insurance or AD&D Insurance benefits.

Coinsurance – When the Plan pays a percentage of Covered Expenses and You pay the rest; this is called Coinsurance.

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 covered by 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 Category 2 (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 Charge(s) – Medically Necessary services or supplies that are covered under this Plan.

Deductible – A fixed dollar amount per person or family of Covered Expenses that You are obligated to pay each calendar year before Medical Benefits are payable.

Dependent – Means:

1. An Employee's spouse if not legally separated or divorced. The Board of Trustees may require the Employee and spouse to submit a marriage certificate to establish their relationship. The coverage for the spouse ends on the last day of the month in which the divorce or legal separation occurs unless COBRA coverage is elected.

2. An Employee's Domestic Partner and dependents who meet certain requirements. See definition of "Domestic Partner" on page 130. Coverage for the Domestic Partner and the Domestic Partner's children who qualify as Dependents ends on the last day of the month in which dissolution of the domestic partnership occurs.

3. a. An Employee's child (including a child of a Domestic Partner, 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 26 so long as the child, age 19 or older, is not enrolled in or eligible to enroll in an employer-sponsored group health plan other than a group health plan of a parent. If a child age 19 or older is enrolled in or eligible to enroll in an employer-sponsored group health plan other than a group health plan of a parent, coverage will end on the last day of the month in which the child enrolled in or became eligible to enroll in an employer-sponsored group health plan other than a group health plan of a parent.

   b. An Employee's unmarried child (including a child of a Domestic Partner, a stepchild, legally adopted child or child placed in an Employee's home pending adoption) who has attained age 26 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 date the child attained age 26.

4. An Employee's unmarried grandchild, niece, nephew or sibling in the custody of the Employee and for whom the Employee is providing the majority of his or her support will be a Dependent if the Employee has been named as legal guardian by a court of competent jurisdiction and properly enrolls the child until the end of the month the grandchild, niece, nephew or sibling attains age 19. Coverage for the grandchild, niece, nephew or sibling can continue beyond age 19 if the grandchild, niece, nephew or sibling meets the criteria in paragraph 3(c) above or is enrolled in an accredited school as a full-time student and has not attained age 26.

   If the grandchild, niece, nephew or sibling is unable to continue as a full-time student at an accredited school because he/she is suffering from a serious Illness or Injury that makes a leave of absence from the accredited school Medically Necessary and a Doctor provides written verification to the Trust Administrative Office that the child's serious Illness or Injury makes a leave of absence Medically Necessary, the child may continue as a Dependent even though not enrolled in an accredited school on a full-time basis. Coverage as a Dependent will continue for the child for up to one year from the time the leave of absence began or the date coverage would otherwise terminate under the terms of the Plan if earlier.

5. In the event that a married couple or Domestic Partners are both covered by the Plan as Employees;

   a. Each will be considered a Dependent of the other; and

b. Each Dependent child of such married couple or Domestic Partners will be considered a Dependent of both individuals. 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.

Domestic Partner – The Employee and another individual who have:

- Registered a Certificate of their Domestic Partnership under California law; and
- Signed and submitted a notarized Affidavit of Domestic Partnership provided by the Plan declaring that both meet all of the following criteria:

1. They are residing together and sharing the common necessities of life;
2. Neither of them is married or registered as the Domestic Partner with any other person in any jurisdiction;
3. Neither of them has been married or had another Domestic Partner at any time during the previous six (6) months. This does not apply if Your prior spouse or Domestic Partner is deceased.
4. They are at least 18 years of age;
5. They are not related by blood kinship closer than would bar marriage in the state where they reside;
6. They are mentally competent to consent to contract; and
7. They are each other's sole Domestic Partner and intend to remain so indefinitely and are responsible for each other's common welfare, including but not limited to food, shelter and other necessary living expenses.

The Board of Trustees may require the Employee and Domestic Partner to submit affidavits, information and documents to establish their Domestic Partner relationship. In the event the Employee and Domestic Partner reside in a city, county or other governmental unit that has a Domestic Partner registry, the Board of Trustees may require the Employee and Domestic Partner submit evidence that they are registered on a governmental body's Domestic Partner registry.

Health and welfare coverage can start the first of the month after (i) the Board of Trustees or their designee has accepted the Domestic Partner relationship; (ii) all enrollment forms are completed and returned to the Trust Administrative Office; and (iii) if applicable, the Employee has made a payment to the Trust Administrative Office to cover the federal and, if applicable, state income taxes for the value of the Employer paid health and welfare coverage provided to the Domestic Partner and, if applicable, his/her children.

The Domestic Partnership will cease to exist on the first day of the month after the date that all the aforementioned criteria for Domestic Partner status are not met.

Durable Medical Equipment – Equipment that: 1) can withstand repeated use; 2) is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Injury or Illness; 3) is not disposable or non-durable; and 4) is appropriate for use in the home.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part.

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 Category 2 (non-bargaining) Employees of 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 Category 2 (Subscription) Agreement approved by the Board of Trustees.

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefit – Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care as these terms are defined in the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act, applicable regulations and the Board of Trustees' good faith interpretation of these terms.

Experimental or Investigative (Investigational) – A treatment, procedure, facility, equipment, drug, device or supply will be considered to be Experimental or Investigative if it falls within anyone of the following categories:

1. It is not yet generally accepted among experts as accepted medical practice for the patient's medical condition.

2. It cannot be lawfully marketed or furnished without the approval of the U.S. Food and Drug Administration or other federal agency, and such approval had not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply was rendered, provided or utilized.

3. It is the subject of ongoing Phase I or Phase II clinical trials, or is the research, Experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses, or if the prevailing opinion among experts regarding any such treatment, procedure, facility, equipment, drug, device, or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnoses.

Determination of whether a treatment, procedure, facility, equipment, drug, device or supply is Experimental or Investigative shall be determined solely by the Trustees, in their sole discretion and judgment, in consultation with experts of their choosing.

Hospital – A facility that:

1. Is licensed (if required) as a Hospital;

2. Is open at all times;

3. Is operated mainly to diagnose and treat Illnesses or Injuries 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 (RNs);
6. Is not mainly a Skilled Nursing Facility, clinic, nursing home, rest home, convalescence home or like place; and
7. Has organized facilities for operative surgery on the premises.

I.B.E.W. – International Brotherhood of Electrical Workers.

Illness – A disorder or disease of the body or mind, including Pregnancy. All Illnesses due to the same cause, or to a related cause, will be deemed one Illness. The donation of an organ or tissue by You for transplanting into another person is considered an Illness.

Injury – An Injury to Your body, including but not limited to an Accidental Bodily Injury.

Inpatient – Confined in a medical facility as an overnight bed patient.

Medical Coverage or Medical Benefits – Benefits in this Plan other than short-term disability benefits, life insurance benefits, AD&D Insurance, vision benefits and dental benefits.

Medically Necessary or Medical Necessity – Only those services, treatments or supplies provided by a Hospital, a Doctor, or other qualified Provider of medical services or supplies that are required, in the judgment of the Board of Trustees based on the opinion of a qualified medical professional, to identify or treat an eligible individual's Injury or sickness and which:

1. Are consistent with the symptoms or diagnosis and treatment of the individual's Injury, disease or sickness, including premature birth, congenital defects and birth defects;
2. Are appropriate according to generally accepted standards of good medical practice;
3. Are not mainly for the convenience of You, a Doctor, Hospital or other Provider;
4. Are not Experimental or Investigative; and
5. Are the most appropriate services, supplies or level of services required to provide safe and adequate care. When applied to confinement in a Hospital or other facility, this means that the covered person needs to be confined as an Inpatient due to the nature of services rendered or due to Your condition, and that You cannot receive safe and adequate care through Outpatient treatment.

The fact that the treating Provider finds that treatment is Medically Necessary is not binding upon the Board of Trustees.

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. Any final review will be based on professional medical opinion.

The requirement for Medical Necessity shall not apply to any service or supply that is covered by the Plan as preventive services. Preventive services mean those services and supplies used for routine physical examinations and any other services which are not for the treatment of an Illness, Injury, Mental Illness or Substance Abuse but which are for prevention of disease and for maintenance of good health provided the service or supply is covered by this Plan.

Medicare – Medical Benefits provided by Title XVIII of the Federal Social Security Act, as amended.

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 Substance Abuse.

Necessary to the Care or Treatment of Illness or Injury – Care recommended by a Provider and commonly recognized in the Provider's profession as proper care or treatment of Your medical needs.

The treatment, services or supplies must not be:

1. For the scholastic, education or vocational training of the Provider;

2. Experimental or Investigative in nature; or

3. Primarily for the convenience of You or a Provider.

Negotiated Rate – The amount Preferred Providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated Rates are determined by the Anthem Blue Cross Preferred Provider Agreements.

Non-Preferred Provider – Any Doctor, Hospital, medical clinic or facility which does not belong to the Preferred Provider Organization (PPO) network recognized by the Trust.

One Continuous Period of Disability – A period of time during which You are Totally Disabled. Successive periods of Total Disability due to the same or related causes will be considered One Continuous Period of Total Disability. When You have successive periods of Total Disability that are due to the same or related causes and which are not separated by two or more continuous weeks after being released for active employment by Your Doctor this is One Continuous Period of Disability.

Out-Of-Pocket Maximum – The portion of Covered Medical Expenses that You must pay, after You meet any applicable Deductibles, before Covered Medical Expenses are paid at 100%.

Outpatient – Treatment received in a setting other than an Inpatient in a medical facility.

Plan – The IBEW / NECA Sound and Communication Health and Welfare Plan as described in the Benefit Booklet.

Plan Document – The health and welfare benefits described in this Benefit Booklet and any amendments, additions or deletions subsequently made.

Preauthorized or Preauthorization – The Plan's requirement for advanced authorization of certain services, supplies or prescription drugs to assess the medical necessity, efficiency and/or appropriateness of health care services or treatment plans. These services will be covered only on a case-by-case basis as determined by the Plan. The term does not include the determination of eligibility for coverage or the payment of benefits under the Plan.

Preferred Provider – Any Doctor, Hospital, medical clinic or facility which belongs to the Preferred Provider Organization (PPO) network recognized by the Trust as a Preferred Provider.

Pregnancy – One's Pregnancy, childbirth or related medical conditions, including complications of Pregnancy.

Primary Care Physician – A Doctor who is responsible for monitoring a person's overall medical care and referring the individual to more specialized Doctors or Physicians for additional care. Primary Care

Physicians practice in the following specialties: group practice, family practice, internal medicine, pediatrics and obstetrics/gynecology.

Protected Health Information – Individually identifiable health information that is not subject to specific exclusions. The definition of Protected Health Information in 45 C.F.R. § 164.501 is adopted for use in the Benefit Booklet.

Provider – Means:

1. A licensed Medical Doctor (MD)
2. A licensed Doctor of Osteopathy (DO)
3. A Chiropractic Physician (DC) (under certain limited conditions)
4. A Doctor of Medical Dentistry (DMD)
5. A Doctor of Dental Surgery (DDS)
6. A Denturist (under certain limited conditions)
7. An Optometrist (OD)
8. A Doctor of Podiatric Medicine (DPM)
9. A Licensed Clinical Psychologist (PhD)
10. A Clinical 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. A Mental Health Practitioner who is a member of the Plan's Preferred Provider Organization network at the time the service is provided.
12. A Master of Science or Arts
13. A Certified Competent Clinician Audiology
14. A 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 Doctor.
15. A Speech Therapist who:
    a. Has a master's degree in speech pathology;
    b. Has completed an internship; and

c. Is licensed as a Speech Therapist by the state in which services are performed (if that state's laws license Speech Therapists).

16. A 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 Doctor who is an MD or DO. This does not apply if applicable law does not allow it.

17. A Nurse Practitioner (Certified)

18. An Occupational Therapist who is licensed as an Occupational Therapist by the state in which care is rendered (if that state's laws license Occupational Therapists), for rehabilitation services rendered upon the written referral of a Doctor.

Reserve Dollar Bank Account – A separate bookkeeping record maintained by the Trust Administrative Office that credits the monetary Contributions that a Contributing Employer pays to the Trust on behalf of an Employee performing work under a Collective Bargaining Agreement.

Room and Board Charges – Charges made by a Hospital or Skilled Nursing Facility for the room, meals and routine nursing services for a person confined as a bed patient. Room and board is limited to the Hospital's prevailing charge for a semiprivate room.

Skilled Nursing Facility – An institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.

Substance Abuse – The regular, excessive and compulsive drinking of alcohol and/or physical, habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

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 or Terminal Illness – The condition has reached a point where recovery can no longer be expected and You are facing imminent death.

Temporomandibular Joint Syndrome (TMJ) – 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.

Totally Disabled – Except for the life insurance benefit means the inability to perform the duties essential to Your occupation or employment.

Total Disability – Except for the life insurance benefit, You will be deemed to have Total Disability under the following circumstances:

1. If an Employee is claiming benefits under this Plan, Total Disability is defined as Your inability to work in Your normal job because of an Illness or Accidental Bodily Injury and under the care of a Doctor.

Trust Administrative Office – United Administrative Services, whose address is 1120 S. Bascom Ave., San Jose, CA 95128-3590.

Trust or Trust Fund – The IBEW / NECA Sound and Communications Health and Welfare Trust Fund.

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.

Utilization Review – The cost management process that determines if Hospital stays or behavioral health disorder treatments are Medically Necessary. Currently, Anthem Blue Cross provides Utilization Review for medical care and Optum Health provides Utilization Review for behavioral health disorder treatment. All in-patient Hospital admissions for both medical treatment and conditions involving behavioral health disorder treatment must be Preauthorized except in the case of emergencies.

You or **Your** – The Employee, Domestic Partner and/or Dependent.

When necessary to the meaning of any term or provision of this Benefit Booklet, 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.

PROFESSIONAL SERVICE PROVIDERS

Third-Party Administrator:

United Administrative Services

Mailing Address
P.O. Box 5057
San Jose, CA 95150-5057

Street Address
1120 S. Bascom Ave.
San Jose, CA 95128-3590

Phone: (408) 288-4400
Toll-Free: 1-800-541-8059

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Auditor

Miller, Kaplan, Arase & Co., LLP

Investment Consultant

Alan D. Biller & Associates, Inc.