IBEW/NECA
SOUND & COMMUNICATIONS
HEALTH AND WELFARE PLAN

Restated Summary Plan Description
and
Plan Document

(For Sound & Communication Actives, Spouses & Dependent Children)

For Benefits in Effect as of

JANUARY 2023

Keep this Summary Plan Description and Plan Document
For Future Reference

Dear Plan Member, Spouse and Dependent:

We are pleased to provide you with this **NEW restated booklet** known as a Summary Plan Description ("SPD") which is both the Summary and the actual Plan document for the IBEW/NECA Sound & Communications Health and Welfare ("Plan"). This booklet contains an explanation of the eligibility provisions and benefits for Active Participants and their Dependents (as defined by the Plan). Additional information on the Plan, including a variety of forms, can be obtained from the Trust Fund's website, which is ***www.soundcommbenefits.com***. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Trust Fund Office at (408) 208-4400. (Throughout this booklet the office will be referred to as the Trust Fund Office or Trust Administrative Office).

Eligible active participants are offered two medical benefit options: (1) provided by contract with the **Kaiser Foundation Health Plan** or (2) through the **Plan's self-funded PPO medical benefits jointly administered with Anthem**. The Plan also provides self-funded prescription and dental care benefits, and vision care, mental health/substance abuse benefits, and life and accidental death and dismemberment benefits through insured contract arrangements.

The Board of Trustees has the discretionary authority to decide all questions about the Plan, including questions about your eligibility for benefits, the amount of any benefits payable to you, and the interpretation of the Plan. No Individual Trustee, Employer, or Union Representative has authority to interpret this Plan on behalf of the Board of Trustees or to act as an agent of the Board of Trustees. The Board of Trustees also has discretion to make any factual determinations concerning any claims under this Plan not delegated by contract to a health care provider or insurance carrier.

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

IBEW/NECA Sound & Communications Health and Welfare Trust Fund
6800 Santa Teresa Blvd., Suite 100
San Jose, CA 95119
Phone: (408) 288-4400 or (877) 827-4239

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

Sincerely,
The Board of Trustees

Plan Participant Website – www.soundcommbenefits.com

As a companion to this Summary Plan Description ("SPD"), the Trust Fund 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 SPD 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.

For questions about eligibility for coverage, premiums, reserve dollar bank account or Health Reimbursement account, claims payments, claim forms and benefit information, and to request a copy of the SPD booklet, please contact the Trust Administrative office at the contact information on the next page.

Depending on the health coverage option you are enrolled in, questions regarding participating providers, clinics, urgent care centers, and covered benefits should be directed to the Insurance Providers at the contact information on the following pages.

Important Plan Contact Information

BOARD OF TRUSTEES

Labor Trustees	Managment Trustees
Dan Romero, Chairman *IBEW Local Union 332* **Herb Watts** *IBEW Local Union 180* **Chuck Vella** *IBEW Local Union 617*	**Doug Lung, Co-Chairman** *NECA Santa Clara Valley Chapter* **Rick Jensen** *JM Electric* **Bill Kuhr** *NECA San Mateo County Chapter*

ADVISORS TO THE PLAN

TRUST ADMINISTRATIVE OFFICE

UAS Administrative Services
Sandy Stephenson & Debbie Wolfe
6800 Santa Teresa Blvd., Suite 100
San Jose, CA 95119
(408) 288-4400
Toll Free: (800) 541-8059

LEGAL COUNSEL

Neyhart, Anderson, Flynn & Grosboll APC
Lois H. Chang & Richard K. Grosboll
369 Pine Street, Suite 800
San Francisco, CA 94104
(415) 677-9440

AUDITOR

Miller Kaplan Arase LLP
Mike Quackenbush & James Capers
44 Montgomery Street, Suite 3701
San Francisco, CA 94104
(415) 402-5600

BENEFIT CONSULTANT

Joseph H. Herrle & Associates, Inc.
Joseph H. Herrle
1800 SW 1st Ave., Suite 280
Portland, OR 97201-5333
Toll Free: (800) 804-2385

INVESTMENT CONSULTANT

Allan Biller & Associates
Simon Lim
535 Middlefield Road, Suite 230
Menlo Park, CA 94025
(650) 328-7283

PHARMACY BENEFIT CONSULTANT

Pharmaceutical Strategies Group (PSG)
Diane Clausen
14881 Quorum Drive, Suite 850
Dallas, Tx 75254
(972) 244-8353

Insurance Providers

Your Service Providers:		Phone Numbers /Websites:
Kaiser Permanente (HMO Plan)	For questions about benefit information or to obtain ID Cards. Refer to Group #919	*Call Kaiser Permanente:* *Toll-Free: 1-800-464-4000* *(Refer to Group # 919)* *or go online to:* ***www.kaiserpermanente.org***
Anthem Blue Cross (Self-Funded PPO Medical Indemnity Plan)	For questions about benefit information or for a list of network providers. Refer to Group #27778514001	*Call Anthem:* *Toll-Free: 1-800-541-8059* *or go online to:* ***www.anthem.com/ca***
MaxorPlus Rx (Pharmacy Benefit Manager)	For questions about prescription drug benefits or to locate a participating retail pharmacy or about your mail order prescriptions.	*Call MaxorPlus:* *Toll-Free: 1-800-687-0707* *or go online to:* ***www.maxorplus.com***
Anthem Blue Cross Dental PPO (Preferred Provider Dental Organization – PPDO)	To locate a participating Preferred Provider dentist.	Call Anthem Blue Cross Dental PPO Toll-Free: 1-800-541-8059 or go online to: **www.anthem.com/ca**
Optum Health (Mental health/Substance Abuse Benefits)	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 VSP 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***
Standard Insurance Company	For questions about your group life and accidental death & dismemberment benefits:	*Call Standard Insurance:* *Toll-Free*: 1-800-628-8600 *Or go online to:* **www.thestandard.com**

TABLE OF CONTENTS

ARTICLE I: INTRODUCTION

The Board of Trustees is pleased to issue this new Benefit Booklet effective January 1, 2022. 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.

Medical, Hospital, Mental Health/Behavioral Health/Substance Abuse Disorder Plan Options. This Plan has two medical plans available to You and Your Dependents. You and Your Dependents can have Medical Benefits provided by (1) Kaiser Permanente Health Maintenance Organization (HMO) option or the (2) Self-Funded Medical Indemnity PPO Plan benefits (through Anthem Blue Cross) described in this Benefit Booklet. At any time or times that the Board of Trustees enters into a new or different contract and/or renewal contract with an HMO, such contract(s) is incorporated in this Plan effective as of the date of such contract, provided same has been executed by the Board of Trustees or a duly authorized representative of the Board of Trustees.

Prescription Benefits. The Board of Trustees has contracted with MaxorPlus to administer prescription drugs for those enrolled under the Self-Funded Medical Indemnity PPO Plan option. For those enrolled in the Kaiser HMO option, prescription drugs are administered through Kaiser.

Additional Benefits. The Board of Trustees also offers the following types of additional benefits subject to certain eligibility provisions and exclusions to You and Your Dependents.

a. ***Dental Benefits.*** Self-funded through Anthem Blue Cross Dental PPO (available to Actives and Dependents).
b. ***Vision Benefits.*** Insured arrangement through Vision Service Plan (available to Actives and Dependents).
c. ***Life Insurance and Accidental Death & Dismemberment Benefits.*** Insured through Standard Insurance Company (available to Actives only).
d. ***Short-Term Disability Benefits.*** Subject to certain eligibility rules this benefit covers non-occupational accidents or illness only (available to Category 1- bargaining unit Employees only).
e. ***Mental Health, Substance Abuse, EAP Provider.*** Regardless of the medical plan You choose, You and Your Dependents are eligible for the member assistance benefits described in this Benefit Booklet.

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
6800 Santa Teresa Blvd., Suite 100
San Jose, CA 95119

Phone Number: (408) 288-4400
Toll Free Number: 1-800-541-8059
Fax Number: (408) 288-4419
Business Hours: 7:30 am to 4:00 pm Monday through Friday
Email: infos&c@uastpa.com
Website: www.sound& commbenefits.com

IMPORTANT INFORMATION

FUTURE PLAN AMENDMENTS

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

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS

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

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

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.

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

NO GUARANTEE OF PROVIDER

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

NO VESTED RIGHTS

Benefits under this Plan are NOT vested. 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 and Kaiser Permanente Plan in their present form. The Board of Trustees may in their sole discretion

amend, reduce, eliminate or otherwise change the Plan at any time and may change, reduce, or discontinue any Plan benefits, in whole or in part, add or delete insurance carriers or benefit providers, at any time and for any class of participants. Moreover, the Board of Trustees may require new or greater co-payments at any time. The Board of Trustees may change the eligibility requirements, change or reduce benefits and require or increase self-payments and any other Plan rules at any time. All benefits are subject to future amendments adopted by the Board of Trustees increasing or decreasing benefits.

ALERT: ONE YEAR PERIOD TO FILE A LAWSUIT

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

ARTICLE II: ELIGIBILITY AND ENROLLMENT PROCEDURES

A. 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. Locals 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

B. 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 5) 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 of this booklet.

C. 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;

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.

D. If You Are Out of Work or Retiring

As long as You have sufficient money in Your Reserve Dollar Bank Account and comply with the rules under Section C. 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 4.

Upon retirement, you can continue to use your reserve dollar bank account for continued coverage under the Plan until your hour bank is exhausted. At that point, you will be offered COBRA continuation coverage under the Plan upon timely payment of the appropriate premium until you are eligible for Medicare. Please also refer to Article VII of the Plan's HRA rules relating to using your supplemental medical account upon retiring.

E. 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 or enters active duty in the Uniformed Services of the United States.

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.

F. 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 Fund for You.

G. 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 in the beginning of this Benefit Booklet).

H. 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.

I. 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) calendar 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.

J. Dependents – Eligibility

Dependent Eligibility. An Employee's Dependents are defined in the Definition of Terms section of the Benefit Booklet.

Coverage Date. 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 14.

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.

K. Special Enrollment Rights

Employees and Dependents have special enrollment rights (other than during open enrollment) in the Self-Funded Medical Indemnity PPO Plan as well as 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 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. Please contact the Trust Fund Office for open enrollment details.

Special Enrollee

A special enrollee is an Employee or Dependent that is allowed to enroll in the Self-Funded Medical Indemnity PPO 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 (including COBRA continuation 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 dependent ceased to qualify as a dependent under the other coverage; 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 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 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 as of the 1st of the month following the date 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 and the appropriate documentation to verify your 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 Program Reauthorization Coverage Act (CHIP)

Under federal law, an Employee or Dependent who is eligible to enroll for Plan coverage but did not enroll under either of the following circumstances will have special enrollment rights.

1. The Employee or Dependent is covered under Medicaid 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 Medicaid 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 (from the loss of Medicaid/CHIP or gaining eligibility for premium assistance under Medicaid/CHIP) 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. More information is available at *www.coveredca.net* or *www.dhcs.ca.gov/services/medi-cal*.

L. Family and Medical Leave

If your Employer has at least 50 Employees, your Employer may be required to continue to pay for your health coverage on the same terms as if you had continued work, during any approved leave under the Federal Family and Medical Leave Act of 1993 (FMLA). 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 within one year of birth or adoption;
    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. Military Caregiver Leave (up to 26 weeks during a 12-month period). To deal with a qualifying exigency (urgent, pressing need or emergency) arising because a spouse, child, next of kin, 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.

M. Continuation of Coverage During Military Service (USERRA)

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. You may then purchase continuation coverage for you and your dependents under the rules included in the COBRA section of this booklet. You should notify the Trust Fund Office if you enter military service for more than 30 days. However, you may elect to waive your rights under federal law. The months of coverage so applied would no longer be available to provide coverage upon you return to covered employment.

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

USERRA Procedures.

1. Upon notification that a Participant has been called to active duty, a Participant's hours will be frozen from the first day of the month following the date the employee begins active duty. Exception: If the Participant begins active duty on the first of any month, the Participant's hours will be frozen as of the first of that month.
2. The Trust Fund office will notify the Participant of the option to elect continuation of Medical, Dental, Disability, AD&D, life and vision coverage by self-paying the premium to the Trust Fund Office. Coverage may be continued for a period that is the lesser of 18 months, or a period that ends on the day the individual fails to apply for, or return to a position as an active Participant of the Plan.
3. Participants must notify the Trust Fund Office of their return from active duty. The Trust Fund Office will restore the Participant's frozen hours, and the Participant will once again be eligible for all benefits that he/she would normally have been eligible for had he/she not been called to active duty.

USERRA Return to Civilian Employment.

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

- If your **service lasts less than 31 days**, you must be available for covered employment on the next calendar day (so long as you had at least 8 hours rest after returning home by normal transportation) following the end of your service. Continuation coverage will end, by the beginning of the first regularly scheduled work period after the end of the last calendar day of duty. This period is extended by the time required to return home safely. If this is impossible or

unreasonable, then you must return as soon as possible.

- If your service lasts for **31 days or more but less than 181 days**, you must be available for covered employment no later than 14 days after the end of your service. Continuation coverage will end, no later than 14 days after completion of your service. If this is impossible or unreasonable through no fault of yours, then you must return as soon as possible.
- If your service lasts for **more than 180 days**, you must be available for covered employment, and continuation coverage will end, no later than 90 days following the end of your service.

Continuation of Coverage.

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 at the applicable rate for active members.

2. If you are absent from covered employment as a result of military service for **less than 31 days** you may elect to continue your coverage at no expense, for the first month.

3. If you are absent from covered employment as a result of military service for **31 days or** more, 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 (the first month of which is free). This right applies only to Dependents covered by the Plan at the time of military service.

4. 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.

5. 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.

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

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

N. 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.

O. Duty to Notify Trust Fund Office

IMPORTANT Duty to Notify Trust Fund Office of Change in Address.

From time to time, the Trust Fund 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.

Important Duty to Notify Trust Fund Office to Preserve Your Rights Under COBRA and USERRA.

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

Under COBRA you or your dependents must inform the Trust Fund Office within 60 days of a divorce, legal separation or loss of dependent status (ex. your child turns age 26) or termination of domestic partnership with your domestic partner. The Trust Fund office will notify you of loss of coverage due to a reduction in hours or the expiration of extended coverage under the Plan's self-pay program, and your employer will provide notice for other Qualifying Events (ex. employee's death, termination of employment, reduction in hours, or Medicare becoming the employee's primary coverage). However, you are encouraged to inform the Trust Fund Office of any Qualifying Event to best ensure prompt handling of your COBRA rights.

Important Duty to Notify Trust Fund Office of Change in Family Situation for Special Enrollment

It is your responsibility to notify the Trust Fund Office within thirty (30) days of adding any new dependents by legal marriage, birth, or legal adoption. If you fail to notify the Trust Fund Office within thirty days following the addition of a new dependent, should you subsequently enroll your dependent your dependent's coverage will not become effective until the first of the month after you have applied and provided any necessary documentation to establish their eligibility as a dependent.

ARTICLE III: DOMESTIC PARTNER COVERAGE, RULES AND PROCEDURES

The Plan's two medical plan options (Self-Funded Medical Indemnity PPO Plan, Kaiser Permanente Plan) offer health and welfare coverage to an Active 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 booklet.

A. Domestic Partnership Coverage Eligibility.

An eligible and covered participant's Registered Domestic Partner (including both same-sex and opposite-sex partners) will be covered provided the Domestic partner is registered with any state or local government agency authorized to perform such registration. Your state of domicile shall be presumed to be California unless clear and convincing evidence to the contrary is provided. If Kaiser has a broker definition of the term "dependent' in its contract with the Plan, than those contract provisions shall govern for purposes of interpreting who is entitled to medical coverage. To be entitled to benefits as a registered Domestic Partner, a Participant and his Domestic Partner must provide the Trust Fund office with: (1) proof that the Domestic Partnership has been registered with the City and County of San Francisco and/or the State or California or other appropriate government agency and (2) updated Enrollment Form. The intent of this section is to comply with the San Francisco Equal Benefits Ordinance. Where the term spouse is used in the Plan, the term shall also mean a registered Domestic partner of Participant provided that the Plan has received timely written notice and proof of such registered Domestic Partnership. There are no requirements for proof of relationship or waiting periods that are not also applied to married lawful spouses except as provided in the registration requirements. 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.**

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 in this booklet; 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 of this booklet.

To the extent required, the Plan shall comply with applicable IRS requirements relating to providing benefits to Domestic Partners, including imputed income tax for the value of the benefits if the Domestic Partner does not qualify as a dependent under IRS rules.

Coverage for the Domestic Partner and the Domestic Partner's Children who qualify as Dependents will terminate on whichever of the following dates is applicable:

(1) On the first day of the month following the date on which he/she no longer qualifies as a Dependent; for example, one of the partner dies, one of the partners marries or the partners no longer live together, or Dissolution of Domestic Partnership occurs.
(2) Date the Participant Employee's health and welfare coverage ends.

IMPORTANT: It is the Participant's responsibility upon termination of the domestic partnership to immediately notify the Trust Fund office and provide written documentation showing such termination of domestic partnership. If the Participant does not timely notify the Trust Fund Office, the Participants and/or the Domestic partner will be held responsible for any and all costs/premium incurred by the Plan for the Participant's maintaining of an ineligible Domestic Partner after termination.

THE PLAN MAY REQUIRE EVIDENCE OF CONTINUED DOMESTIC PARTNERSHIP STATUS AT ANY TIME.

B. Tax Consequences of Domestic Partnership Coverage

Imputed Income. 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.

Timely Payment must be Made for Domestic Partner Coverage. A payment to the Plan 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 of this booklet.

W-2 Form or Certification Form. 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.

C. Coordination of Benefits with Other Group Coverage

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.

D. Duty to Notify the Trust Fund Office

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	6800 Santa Teresa Blvd., suite 100
San Jose, CA 95150-5057	San Jose, CA 95119

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 Employee and/or Domestic Partner shall be legally responsible for any payments or premiums made by the Plan from the date the Domestic Partner became ineligible for coverage. Also, 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.

ARTICLE IV: PLAN MEDICAL OPTIONS

A. Information on Plan Options.

An Employee participating in the Plan have the option of enrolling in one of the two medical and prescription drug plans: the Self-Funded Medical Indemnity PPO Plan described in this Benefit Booklet or the Kaiser Permanente Plan (HMO). 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 the Kaiser Permanente Plan. **For a summary comparison in chart form of the medical options available please refer to page ___of this booklet below.**

What Is the Difference Between an HMO and a PPO? Traditional HMO plans (ex. 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) and 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 Kaiser Permanente Plan to the Self-Funded Medical Indemnity PPO Plan or from the Self-Funded Medical Indemnity PPO Plan to the Kaiser Permanente Plan. The annual open enrollment period is determined and announced by the Board of Trustees.

If You are considering the Kaiser Permanente Plan, You should refer to the evidence of coverage booklet offered by Kaiser Permanente for the schedule of benefits, limitations, exclusions and the claim appeal procedures. Contact the Trust Administrative Office for a Benefit Booklet.

B. 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;
- Substance Abuse and Mental Health;
- Prescription drug;
- Dental;
- Vision;
- Member assistance;
- Life insurance
- Accidental death and dismemberment; and
- Short-term disability.

C. 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.

COVID-19 Coverage During Public Health Emergency.

1. **COVID-19 Testing, Diagnostic Services or Items Coverage.** Effective March 5, 2020, the Plan's HMO coverage through Kaiser will waive all cost-sharing (deductibles, copayments, and coinsurance) for all medically necessary screening and tests to detect COVID-19 during the COVID-19 public health emergency period. This COVID-19 coverage extends to any diagnostic services or items including the visit (such as an in-person or telehealth visit), associated lab testing, and radiology services provided in an urgent care center, hospital, an emergency room or medical office that results in an order for an administration of the COVID-19 testing or screening but only to the extent such items and services relate to the furnishing or administration of the test or to the evaluation of the need for a test. This cost-sharing reduction applies to all Kaiser Permanente and other participating providers. Prior authorization is not required for diagnostic services related to COVID-19 testing. Please note, however, COVID-19 Testing claims for non-Kaiser network or non-participating Kaiser providers may be denied by Kaiser unless received through emergency services.

   Coverage of Over-the-Counter ("OTC") COVID-19 Tests. Effective for purchases on or after January 15, 2022 and during the public health emergency period, the Plan's current HMO Insurer through Kaiser will provide coverage for, including reimbursement of, all OTC tests (also known as at-home tests or self-tests): (a) approved, cleared or authorized by the FDA, (b) test that received FDA authorization for emergency use, (c) state authorized test and state has notified the Dept. of HHS, and (d) other tests that the Secretary of HHS determined appropriate in guidance during the public health emergency period, to detect the SARS-COV-2 (the virus that causes coronavirus disease 2019) or the diagnosis of COVID-19, purchased through pharmacies, retail stores and online retailers, without any cost-sharing, prior authorization or medical management requirements and without a prescription or involvement of a health care provider or individualized clinical assessment.

   Pursuant to federal guidance, the Insurer is permitted (but not mandated) to make quantity and cost limitations under the following Safe Harbors pursuant to FAQ Part 51. If the Safe Harbor requirements are met the Plan is permitted to implement the following limitations:

   (a) Cost Limits (Through Pharmacy Network or Direct Coverage). The Insurer is permitted to limit reimbursement from a non-preferred pharmacy or other retailers to the lesser of: (i) the actual price of the test or (ii) $12 per test, provided that the:

   (i) Insurer provides access to direct-to-consumer coverage (based on the facts and circumstances such as the availability of tests and/or supply shortage), without cost-sharing (meaning the participant does not pay an upfront cost and instead the plan or its contracted entity pays the preferred pharmacy or retailer directly) of OTC COVID-19 tests through a preferred pharmacy network or other retailers, including direct-to-consumer shipping programs; and

   (ii) Insurer takes reasonable steps to provide adequate access to OTC COVID-19 tests through an adequate number of retail locations (meaning at least one in-person mechanism and one direct-to-consumer shipping arrangement which could be provided via online or by telephone or through pharmacy network or other non-pharmacy retailers or drive-through or walk-up distribution site).

   (b) Quantity Test limit. The Insurer permitted to limit OTC COVID-19 tests without a prescription or provider involvement, to no less than 8 tests per covered individual (ex. Participant, Dependent Spouse, Dependent Child) per 30-day period or calendar month. In applying the quantity limit of 8, the Plan may count each test separately, even if multiple tests are sold in one package. The Plan is permitted to set more generous limits although not mandated.

If the above Safe Harbors (a) is not met (for example, if there are delays that are significantly longer than the amount of time it takes to receive other items under, if applicable, the Insurer's direct-to-consumer shipping program), the Insurer must provide coverage of the OTC COVID-19 test without cost-sharing and cannot deny coverage and cannot set limits relating to reimbursement on the amount of OTC COVID-19 tests.

If the above Safe Harbor (b) is not met (for example, OTC COVID-19 test with doctor's note), the Insurer must provide coverage of the OTC COVID-19 test without cost-sharing and cannot deny coverage and cannot set quantity limits.

For Participants and Dependents enrolled in the Kaiser HMO Plan option, please contact Kaiser for more information on how to file a claim for reimbursement or any direct coverage arrangements (if applicable) for OTC COVID-19 tests. Kaiser's website is available at https://healthy.kaiserpemenanet.org.

2. **COVID-19 Treatment.** Effective April 1, 2020 to December 31, 2020 unless superseded by government action or extended by Kaiser, if a Kaiser Plan Participant or Dependent is diagnosed with COVID-19, charges such as out-of-pocket costs for treatment of COVID-19 will be covered for inpatient medical, inpatient pharmacy, outpatient medical, office visits, telemedicine, hospitalization, emergency room, urgent care and transportation costs). This means any out-of-pocket costs, co-payments or other cost-share related to a positive COVID-19 diagnosis and treatment (including hospital stay) will be waived by Kaiser.

3. **COVID-19 Vaccination and Preventive Services Coverage.** Effective April 1, 2020 (or whatever date is required per further government regulation and/or guidance), the Plan's HMO coverage with Kaiser will also cover, at no cost any qualifying coronavirus preventive service defined as an item, service or immunization that is intended to prevent or mitigate coronavirus disease 2019 that has received either an "A" or "B" in the recommendation of the United States Preventive Services Task Force ("USPSTF") or the Advisory Committee on immunization Practices of the Centers for Disease Control and Prevention ("CDC"). The Plan will also cover any COVID-19 vaccine that becomes available if recommended by the USPSTF or CDC. The qualifying coronavirus preventive services or vaccine coverage will be provided within 15 business days after the recommendation was made by the USPSTF or CDC.

IBEW / NECA SOUND & COMMUNICATIONS HEALTH & WELFARE PLAN 2018
MEDICAL PLAN OPTIONS
BENEFIT SUMMARY

Two Medical plan options are offered: 1) The Trust Self-Funded Medical Indemnity Plan (a PPO Plan) and 2) Kaiser Permanente (an HMO Plan). With two options, you are able to select the plan that works best for your needs.

MEDICAL OPTIONS

PLAN FEATURES	TRUST SELF-FUNDED MEDICAL INDEMNITY PLAN		KAISER HMO PLAN Group #919
	In-Network	Out-of-Network	
Provider Network	Anthem Blue Cross PPO	Use Any Provider	Kaiser Permanente
Network Service Area	California		California
Who Provides Care / Provider Choice	Any medical provider. To receive the highest level of benefits, use an Anthem Blue Cross PPO network provider. Note: If you are referred to an out-of-network provider by an in-network provider, out-of-network benefits still apply.		Kaiser Permanente doctors and facilities only
Calendar-Year Deductible	$100 per person, up to $300 per family	$100 per person, up to $300 per family	None
Calendar-Year Out-of-Pocket Maximum for Covered Expenses	$2,500 per person, up to $5,000 per family	No out-of-pocket maximum. You are responsible for 20% of ALL expenses.	$1,500 per person, up to $3,000 per family
Medical Plan Annual Maximum	Unlimited		Unlimited
Medical Plan Lifetime Maximum	Unlimited		Unlimited
Eligibility Age Limits for Dependent Children	Under age 26.		Same

Preauthorization Requirements	Your physician is responsible for obtaining any required preauthorization through Anthem Blue Cross.	You or your physician must contact Anthem Blue Cross at least seven days before: • Hospital admission • Use of outpatient facility • Certain diagnostic procedures • Outpatient surgery	All preauthorizations must be coordinated through your Kaiser primary care physician.

PLAN FEATURES	TRUST SELF-FUNDED MEDICAL INDEMNITY PLAN		KAISER HMO PLAN Group #919
	In-Network	Out-of-Network	
Benefits for Most Covered Services	After calendar-year deductible is applied, plan pays:		You pay a $15 copay per visit. No benefits are payable at non-Kaiser facilities, except in case of emergency.
	80% of Anthem Blue Cross negotiated rate except for inpatient Hospital charges. 90% of Anthem Blue Cross negotiated rate for inpatient Hospital charges.	80% of usual, customary and reasonable charges. Except No Surprises Act covered services same as In-Network No out-of-pocket maximum. You are responsible for 20% of ALL expenses.	
Preventative Care Benefits – Preventative Physical Exams	Plan pays 100% of eligible expenses for annual preventative physical exam in an Anthem Blue Cross network provider doctor's office. **Age frequency applies.** Refer to Summary Plan Description. No deductible applies.	For certain preventive services the Plan will pay 80% of usual, customary and reasonable charges. (See page 22 of this booklet for a list of what is covered).	Plan pays 100%. Annual routine physical examinations for employment, sports, college entrance, etc. not covered.
Well Baby Care	Plan pays 100% of Anthem Blue Cross negotiated rate up to 8 well baby visits. (Infants through age 36 months) No deductible applies.	No benefit provided out-of-network	Plan pays 100%. (Infants through age 23 months)
Immunizations and Vaccinations	Plan pays 100% for children up to 36 months of age for physician-recommended immunizations and vaccinations. Refer to Summary Plan Description.	No benefit provided out-of-network	Plan pays 100%. For children under 2 years of age, refer to Well Baby Care.
Diagnostic Test (X-Ray, Blood Work)	Plan pays 100% of Anthem Blue Cross PPO network provider services. Calendar-year deductible is waived.	Plan pays 80% of usual, customary and reasonable charges after calendar-year deductible is applied.	Plan pays 100%.
Imaging (CT / PET scans, MRI's)	Plan pays 80% of Anthem Blue Cross negotiated rate.	Plan pays 80% of usual, customary and reasonable charges after calendar-year deductible is applied.	Plan pays 100%.
Infertility Treatment	No benefit provided.		Limited benefits. Contact Kaiser for specific coverage.

PLAN FEATURES	TRUST SELF-FUNDED MEDICAL INDEMNITY PLAN		KAISER HMO PLAN Group #919
	In-Network	Out-of-Network	
Inpatient Hospital and Outpatient Facility Services	After calendar-year deductible is applied, plan pays:		Inpatient – Plan pays 100% after you pay $100 copay per admission. Outpatient – Plan pays 100% after you pay $15 copay per procedure.
	90% of Anthem Blue Cross negotiated rate; calendar-year deductible is waived when admitted to an in-network inpatient facility. See preauthorization requirements.	80% of usual, customary and reasonable charges except No Surprises Act covered services same as In-Network. No out-of-pocket maximum. You are responsible for 20% of ALL expenses.	
Emergency Room Facility Charges	Plan pays 80% of Anthem Blue Cross negotiated rate. No deductible applies.	Plan pays 80% of usual, customary and reasonable charges after calendar-year deductible is applied. No Surprise Act Covered items and services covered same as In-Network.	Plan pays 100% after you pay $100 copay. Copay is waived if you are admitted to hospital as inpatient.
Urgent Care Center Services	After calendar-year deductible is applied, plan pays:		Plan pays 100% after you pay $15 copay.
	80% of Anthem Blue Cross negotiated rate.	80% of usual, customary and reasonable charges.	
Ambulance	After calendar-year deductible is applied, plan pays:		Plan pays 100%.
	80% of Anthem Blue Cross negotiated rate.	80% of usual, customary and reasonable charges. No out-of-pocket maximum. You are responsible for 20% of ALL expenses.	
Chiropractic and Acupuncture Services	After calendar-year deductible is applied, plan pays:		You pay a $15 copay per visit for up to 30 visits per calendar year.
	80% of Anthem Blue Cross negotiated rate up to 20 visits per calendar year.	80% of usual, customary and reasonable charges up to 20 visits per calendar year. No out-of-pocket maximum. You are responsible for 20% of ALL expenses.	
Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST)	After calendar-year deductible is applied, plan pays:		You pay a $15 copay per visit.
	80% of Anthem Blue Cross negotiated rates.	80% of usual, customary and reasonable charges. No out-of-pocket maximum. You are responsible for 20% of ALL expenses.	

MENTAL HEALTH BENEFIT			
PLAN FEATURES	**TRUST SELF-FUNDED MEDICAL INDEMNITY PLAN**		**KAISER HMO PLAN Group #919**
	In-Network	**Out-of-Network**	
Calendar Year Deductible	$100 per person, up to $300 per family	$100 per person, up to $300 per family	None
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.	$1,500 per person, up to $3,000 per family
Mental / Behavioral Health Inpatient Services (**THROUGH OPTUM HEALTH)**	Unlimited days based on medical necessity. Pays 90% of Optum Health's negotiated rates after calendar-year deductible is applied.	Unlimited days based on medical necessity. Pays 80% of usual, customary and reasonable charges after calendar-year deductible is applied.	You pay $100 copay per admission at Kaiser facilities.
Mental / Behavioral Health Outpatient Services (**THROUGH OPTUM HEALTH)**	Unlimited visits based on medical necessity. Pays 80% of Optum Health's negotiated rates after calendar-year deductible is applied.	Unlimited visits based on medical necessity. Pays 80% of usual, customary and reasonable charges after calendar-year deductible is applied.	You pay $15 copay per visit (individual basis) or $7 copay per visit (group basis) at Kaiser facilities.

SUBSTANCE ABUSE BENEFIT			
PLAN FEATURES	**TRUST SELF-FUNDED MEDICAL INDEMNITY PLAN**		**KAISER HMO PLAN Group #919**
	In-Network	**Out-of-Network**	
Substance Abuse Disorder Outpatient Services (**THROUGH OPTUM HEALTH)**	After calendar-year deductible is applied, plan pays:		You pay $15 copay per visit (individual basis) or $5 copay per visit (group basis) at Kaiser facilities.
	Unlimited visits based on medical necessity. Pays 80% of Optum Health's negotiated rates after calendar-year deductible is applied.	Unlimited visits based on medical necessity. Pays 80% of usual, customary and reasonable charges after calendar-year deductible is applied.	
Substance Abuse Disorder Inpatient Services (**THROUGH OPTUM HEALTH)**	After calendar-year deductible is applied, plan pays:		You pay $100 copay per admission at Kaiser facilities.
	Unlimited days based on medical necessity. Pays 90% of Optum Health's negotiated rates after calendar-year deductible is applied.	Unlimited days based on medical necessity. Pays 80% of usual, customary and reasonable charges after calendar-year deductible is applied.	

BENEFIT COMPARISON CHART

PLAN FEATURES	TRUST SELF-FUNDED MEDICAL INDEMNITY PLAN		KAISER HMO PLAN Group #919
	In-Network	Out-of-Network	
Prescription Drugs	**Retail Drugs** (up to 30-day supply) – **Only at participating pharmacies** • Generic – You pay $10 copay. • Preferred Brand – You pay 20%; $15 minimum up to a $25 maximum copay. • Non-Preferred Brand – You pay 30%; $30 minimum up to a $75 maximum copay. **Mail Order Drugs** (up to 90-day supply) – **Only through Postal Prescription Services (PPS)** • Generic – You pay $20 copay. • Preferred Brand – You pay 20%; $40 minimum up to a $75 maximum copay. • Non-Preferred Brand – You pay 30%; $75 minimum up to a $150 maximum copay. **Some drugs require preauthorization.** Medical plan deductible and coinsurance amounts do not apply to this benefit feature.		**Retail Drugs** (up to 30-day supply) – **Only at Kaiser pharmacy** • Generic – You pay $10 copay. • Brand – You pay $25 copay. **Mail Order Drugs** refills only (up to 100- day supply) – **Only through Kaiser Mail Order Service** • Generic – You pay $20 copay. • Brand – You pay $50 copay. • Not all drugs are available through mail order. **Specialty Drugs** (up to 30-day supply) – • 20% coinsurance (not to exceed $150).

ARTICLE V: 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 or Kaiser Permanente Plan.

A. 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 (ex. 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.

B. What Is COBRA Continuation Coverage?

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), requires group health plans offer 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 (ex. 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 (except for gross misconduct).

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 (ex. Kaiser Permanente Plan) because any of the following qualifying events happen:

1. Your participant spouse dies;
2. Your participant spouse's hours of employment are reduced;
3. Your participant spouse's employment ends for any reason (except for gross misconduct);

4. Your participant spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from Your participant 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 (ex. 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 124.

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 (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.

C. Notices and Elections of COBRA Continuation Coverage

Under the Self-Funded Medical Indemnity PPO Plan and an insured plan (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 Obligation to Notify the Trust Fund Office: 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
P.O. Box 5057
San Jose, CA 95150-5057

Street Address
6800 Santa Teresa Blvd, Suite 100.
San Jose, CA 95119

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 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.

D. Benefits Available Under COBRA Continuation Coverage

You, Your spouse and each Dependent child has the right to elect COBRA continuation coverage for: (1) **Core Benefits-** medical and prescription drug coverage only, or (2) **Core Plus Non-Core Benefits -** 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 of the Plan is modified, COBRA continuation coverage will be modified in the same way. All family members must select the same coverage.

E. 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.

F. 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. Under federal law, the cost may not exceed 102% (which factors in COBRA administrative expenses of 2%) (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. If the cost changes, the Plan will revise the charge you are required to pay.

G. 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 (ex. 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
P.O. Box 5057
San Jose, CA 95150-5057

Street Address
6800 Santa Teresa Blvd, Suite 100.
San Jose, CA 95119

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

Street Address
6800 Santa Teresa Blvd, Suite 100.
San Jose, CA 95119

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.**

H. 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. Failure to Timely Pay Premium. The premium is not paid by the end of the grace period;
2. Medicare Entitlement. After electing COBRA continuation coverage, You, Your spouse or Dependent child becomes enrolled in Medicare benefits (Part A, Part B or both);
3. Covered Under Other Plan. 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. Employer No Longer Contributes to the Plan. 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. No Longer Disabled. 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.

I. 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.

J. 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.

K. Transfer Rights

If You are covered by the 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.

L. 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 (ex. 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 (ex. 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.

M. More Information about COBRA Continuation Coverage

Questions concerning the Self-Funded Medical Indemnity PPO Plan or an insured plan (ex. 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.

N. 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.

ARTICLE VI: SELF-FUNDED MEDICAL INDEMNITY PPO PLAN BENEFITS

A. Anthem Blue Cross - Preferred Provider Organization (PPO) Program

The Plan has contracted with the Anthem Blue Cross Preferred Provider network to jointly administer its self-funded medical benefits. As part of the Plan'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 Anthem Blue Cross PPO Network. 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 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).

B. 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.

C. 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.

D. 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

E. 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

F. 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 unless it is for a claim subject to the No Surprises Act which prohibits a Non-Preferred Provider from balancing billing you.

To 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. Please also see Article XXI, Section J of this booklet for your rights concerning prohibited balance billing pursuant to the No Surprises Act for certain types of claims.

G. 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.

H. 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.

I. Out-of-Pocket Maximum

Your Out-Of-Pocket Maximum, (excluding the Deductible for certain services, premiums, and health care the Plan doesn't cover which do not count toward the Out-Of-Pocket Maximum), 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.**

J. 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.

K. 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. (The below covered charges are subject to change at any time. Please contact the Trust Administrative Office for the most recent covered charges).

1. **Confinement in Hospital.** Semi-private room and board and routine nursing for confinement in a Hospital **(Preferred Provider covered at 90%).**

2. **Confinement in Skilled Nursing Facility.** 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.** 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. **Private Duty Nursing.** 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. **Rehabilitative Speech Therapy.** 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. **Repair of Teeth/Accidental Bodily Injury.** 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. Effective January 1, 2022, licensed air ambulance (meaning medical transport by a rotary-wing air ambulance or fixed-wing air ambulance including inter-facility transports) includes both in-network and non-preferred provider air ambulance services are covered if the Plan determines that the location and nature of the illness or injury made air transportation cost effective or necessary to avoid the possibility of a serious complication or loss of life. The Out-of-Network rate payable for Non-Preferred provider air ambulance services will be determined per the No Surprise Act (Public Law 116-260, Division BB), effective January 1, 2022 under Article XXI, Section H. of this booklet).

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.** Effective January 1, 2019, preventive care benefits for routine medical examinations (including but not limited to office visits, immunizations, and screenings) will be provided and paid for in accordance with the recommendations and guidelines set by the federal government pursuant to the Patient Protection and Affordable Care Act, as amended. Benefits will be provided at no charge (meaning no copayment, co-insurance, deductible or other cost-sharing requirement will be imposed) to you or your covered family members, if preventive care services are by a Preferred Provider only. The Plan will cover recommended preventive services regardless of you and/or your covered family member's sex assigned at birth, gender identity or gender of the individual otherwise recorded by the Plan. There is no coverage for preventive care services obtained from a non-Preferred provider except as provided in Section d below.

This Plan may use reasonable and medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in this section to the extent not specified in the applicable recommendation or guideline.

Please note if a preventive care service is not listed in the federal government's recommendations and guidelines the Plan's applicable cost-sharing may apply. Note: The Plan will cover a new guideline or recommendation effective with the calendar year that begins on or after one (1) year from the date the new recommendation or guideline is issued or adopted, as applicable. This Plan does not cover any preventive care item or service after the date it is no longer included in the applicable recommendation or guideline, unless such coverage is provided for elsewhere in this Plan. In the general, the following provisions will apply and this Plan will cover all of the preventive services listed in the federal government's recommendations and guidelines subject to change (**for the latest list of federal government's guidelines for preventive care, see https://www.healthcare.gov/coverage/preventive-care-benefits/):**

a. Medically necessary preventive services will be provided in accordance with items or services with a rating of "A" or "B" in the current recommendations made by the **U.S. Preventive Services Task Force**.

b. Annual Women's Examinations. For women, preventive care and screenings will be provided for in comprehensive guidelines supported by the **Health Resources and Services Administration (HRSA)**. Examples of covered services include annual well-women visits, contraceptive methods and counseling, pap smear examinations, counseling on sexually

transmitted infections, HIV Counseling and Screening, Human Papillomavirus DNA Testing, and breastfeeding support for both prenatal and postnatal support and counseling.

c. Well Baby Care. For infants, children and adolescents, medically necessary preventive care benefits and evidence-informed preventive care and screenings will be provided in accordance with recommendations then in effect at the time the service is provided under the Bright Future guidelines that are developed by the **Health Resources and Services Administration** and the **American Academy of Pediatrics**.

d. Non-Preferred Provider Covered Preventive Care Services. Preventive care services obtained from a non-preferred provider are excluded except for the following preventive care services:

(i) Immunizations for children (over age three), adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevent are covered at 80% of the reasonable and customary charge after the Deductible is met.
(ii) Annual pap smear, pelvic, breast and mammogram examinations are covered at 80% of the reasonable and customary charge after the Deductible is met.
(iii) Well Baby visits (including medically necessary immunizations) for the first three (3) years of a child's life are covered at 80% of the reasonable and customary charge. This benefit is NOT subject to the Deductible.
(iv) Colonoscopy is allowed once every ten (10) years if you are over the age of 50. A colonoscopy will be allowed before age 50 or more often than once every ten (10) years if the colonoscopy is medically necessary. A Colonoscopy will be paid at 80% of the reasonable and customary charge after the deductible has been met.

17. **Immunizations for general use for both adults and children.** Immunizations are covered for children, adolescents and adults, as part of a routine physical or as needed even for travel, or any activity the employee is undertaking so long as it is recommended by the **Advisory Committee of Immunization Practices (ACIP)** and the **Centers for Disease Control and Prevention (CDC).**

18. **Maternity Care Expenses (Employee, Spouses & Dependent Children) as follows**:

    Maternity care expenses are covered the same as any other Illness and are provided to You or Your spouse or your Dependent Child up to age 26 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.

    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 myofascial 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.*

    Effective July 1, 2016, there shall be no dollar limit maximum for each type of procedure and to all charges incurred as a result of the preauthorized and medically necessary transplant or replacement of organ or tissue procedures:

    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.

26. **Transgender Services.** Effective January 1, 2017, procedures or treatments, including but not limited to breast augmentation, tracheal shave, facial feminization surgery, lipoplasty of the waist, rhinoplasty, face lifts, blepharoplasty, voice modification therapy and surgery, hormonal therapy, for transgender services determined to be medically necessary by a licensed physician will be covered under the Plan. Medically necessary transgender benefits are determined in accordance with the World Professional Association for Transgender Health Standards of Care ("WPATH") and the terms and conditions of the Plan that apply to all other covered medical and mental health conditions, including medical necessity requirements, utilization management and exclusions. For example, transgender surgery, if medically necessary and meeting the guidelines of the Plan, would be covered on the same basis as any other covered medically necessary surgery. Procedures that are determined not to be medically necessary are excluded. Surgery or prescription drugs related to transgender services are subject to prior authorization in order for coverage to be provided.

27. **COVID-19 COVERAGE DURING PUBLIC HEALTH EMERGENCY.**

A. **COVID-19 Testing, Diagnostic Services or Items Coverage.** Effective March 18, 2020, the Plan will cover charges for the all tests to detect the SARS-COV-2 or COVID-19 (also known as the Coronavirus) or the diagnosis of the virus that causes COVID-19 at no cost (meaning no copayment, deductible or coinsurance) for tests approved, cleared or authorized by the FDA and additional forms of testing such as (a) a test that a test developer intends or has requested FDA authorization for emergency use, (b) a state authorized test and the state has notified the Department of Health and Human Services, and (c) other tests that the Secretary of Health and Human Services determines appropriate in guidance) developed during the COVID-19 public health emergency period at both an in-network Provider or non-network Provider facility. This COVID-19 coverage extends to any diagnostic services or items provided during a medical visit including an in-person or telehealth visit to a doctor's office, urgent care center or an emergency room that results in an order for an administration of the SARS-COV-2 or COVID-19 testing or screening but only to the extent such items and services relate to the furnishing or administration of the test or to the evaluation of the need for a test. Prior authorization or other medical management requirements is not required for diagnostic services related to SARS-COV-2 or COVID-19 testing.

Pricing of Diagnostic Testing Out-of-Network. Per Section 4202 of the CARES Act, the Plan or Insurer will pay or reimburse for COVID-19 diagnostic tests as follows: (a) an existing negotiated rate if there is one or (b) in the absence of a pre-existing negotiated rate, the cash price listed by the diagnostic test provider on the public internet website of such provider.

Coverage of Over-the-Counter ("OTC") COVID-19 Tests. Effective for purchases on or after January 15, 2022 and during the public health emergency period, the Plan (through Anthem Blue Cross for its Self-funded PPO option and through Kaiser for its Insured/HMO option), and its Pharmacy Benefit Manager (currently MaxorPlus) will provide coverage for, including reimbursement of, all OTC tests (also known as at-home tests or self-tests): (a) approved, cleared or authorized by the FDA, (b) test that received FDA authorization for emergency use, (c) state authorized test and state has notified the Dept. of HHS, and (d) other tests that the Secretary of HHS determined appropriate in guidance during the public health emergency period, to detect the SARS-COV-2 (the virus that causes coronavirus disease 2019) or the diagnosis of COVID-19,

purchased through pharmacies, retail stores and online retailers, without any cost-sharing, prior authorization or medical management requirements and without a prescription or involvement of a health care provider or individualized clinical assessment.

Pursuant to federal guidance, the Plan, Pharmacy Benefit Manager and Insurer are permitted (but not mandated) to make quantity and cost limitations under the following Safe Harbors pursuant to FAQ Parts 51 and 52. If the Safe Harbor requirements are met the Plan is permitted to implement the following limitations:

(a) Cost Limits (Through Pharmacy Network or Direct Coverage). The Plan or Insurer are permitted to limit reimbursement from a non-preferred pharmacy or other retailers to the lesser of: (i) the actual price of the test or (ii) $12 per test, provided that the:

(i) Insurer provides access to direct-to-consumer coverage (based on the facts and circumstances such as the availability of tests and/or supply shortage or tests from limited number of manufacturers via contractual arrangement), without cost-sharing (meaning the participant does not pay an upfront cost and instead the plan or its contracted entity pays the preferred pharmacy or retailer directly) of OTC COVID-19 tests through a preferred pharmacy network or other retailers, including direct-to-consumer shipping programs; and

(ii) Insurer takes reasonable steps to provide adequate access to OTC COVID-19 tests through an adequate number of retail locations (meaning at least one in-person mechanism and one direct-to-consumer shipping arrangement which could be provided via online or by telephone or through pharmacy network or other non-pharmacy retailers or drive-through or walk-up distribution site).

(b) Quantity Test limit. The Plan or Insurer is permitted to limit OTC COVID-19 tests without a prescription or provider involvement, to no less than 8 tests per covered individual (ex. Participant, Dependent Spouse, Dependent Child) per 30-day period or calendar month. In applying the quantity limit of 8, the Plan may count each test separately, even if multiple tests are sold in one package. The Plan is permitted to set more generous limits although not mandated.

If the above Safe Harbors (a) is not met (for example, if there are delays that are significantly longer than the amount of time it takes to receive other items under, if applicable, Plan's direct-to-consumer shipping program), the Plan must provide coverage of the OTC COVID-19 test without cost-sharing and cannot deny coverage and cannot set limits relating to reimbursement on the amount of OTC COVID-19 tests.

If the above Safe Harbor (b) is not met (for example, OTC COVID-19 test with doctor's note), the Plan must provide coverage of the OTC COVID-19 test without cost-sharing and cannot deny coverage and cannot set quantity limits.

To address suspected fraud or abuse the Plan is permitted to require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of the OTC COVID-19 test or require a self-attestation.

For OTC COVID-19 tests available through the MaxorPlus prescription pharmacy network and how to file a claim for reimbursement with MaxorPlus if you purchase a At-Home test out-of-network, please call MaxorPlus at 1-800-687-0707.

B. <u>COVID-19 Treatment</u>. Effective March 13, 2020 and hereby extended through December 31, 2021, if a Plan Participant or Dependent is diagnosed with COVID-19, charges for treatment of COVID-19 it will be covered in full (including hospital admission if applicable) if performed at a PPO network Provider facility as provided in this Plan (without a co-pay or deductible or coinsurance). COVID-19 treatment received at a non-PPO network Provider will be covered in

the same manner and cost-sharing as other medical necessary treatments performed at a non-network Provider pursuant to the Plan terms (Participant pays 20% of the cost after deductible).

C. COVID-19 Vaccination and Preventive Services Coverage. Effective the earlier of January 1, 2021 or 15 business days after the date on which the United States Preventive Services Task Force ("USPSTF") or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") makes an applicable recommendation relating to qualifying COVID-19 immunizations the Plan, through its medical providers (such as Anthem Blue Cross and Kaiser) and pharmacy benefit manager (MaxorPlus), throughout the duration of the COVID-19 public health emergency, will cover approved COVID-19 vaccinations and immunizations. Once it becomes available to the public and subject to future government guidance, COVID-19 vaccinations will be available to all eligible participants and dependents at **no cost (meaning no copayment, coinsurance or deductible) whether received in-network and out-of-network and without prior authorization at a doctor's office, medical facilities, governmental health facilities, including participating pharmacies with Kaiser and through the MaxorPlus pharmacy benefit manager.**

Subject to further government guidance, the cost of the vaccine itself will be covered by the federal government but the cost of the administration of the shots will be covered by the Plan.

For network providers, reimbursement for administration of the shots will be based on the Plan's agreed upon contracted rate with Anthem Blue Cross (including MaxorPlus the Plan's pharmacy benefit manager).

For non-network providers (subject to future government guidance), reimbursement for administration of the shots will be based on a reasonable rate such as: (a) an existing negotiated rate if there is one or (b) in the absence of a pre-existing negotiated rate, the cash price listed by the provider on the public internet website of such provider or the Medicare reimbursement rate.

Medical and Pharmacy Benefit Providers are prohibited from seeking reimbursement from participants and dependents for the vaccine itself including the vaccine administration costs whether as a cost-sharing or balance billing.

Furthermore, pursuant to jointly released DOL, HHS and Treasury guidance (released February 26, 2021 in FAQ 44) the Plan and Insurer cannot deny coverage of the COVID-19 vaccination available to a participant and dependent because the individual receiving the vaccine is not eligible under the categories prioritized for early vaccination in his/her state or locality.

D. Prescription Drug Re-fill During Public Health Emergency. Effective April 1, 2020 and only through December 31, 2020, the self-funded PPO group health Plan's prescription drug early re-fill limits have been extended to allow eligible participants and dependents to re-fill medications early so long as there are refills available with their prescription. This means that early medication refill limits on 30-day prescription retail maintenance medications will be waived. Plan Participants and/or members are encouraged to use the 90-day mail order benefit. Exception: Early refills for any controlled prescription medications or opioids will continue to require prior authorization request to be received from your prescribing physician.

E. Telehealth/Telemedicine Coverage. Effective March 13, 2020 and during the period of the COVD-19 public health emergency, the Plan through its self-funded Anthem PPO coverage, will cover all medically necessary visits and/or treatments, subject to current Plan provisions relating to reimbursement of in-network and out-of-network providers, the following virtual services provided by a medical practitioner: (a) telehealth/telemedicine visits (a visit between a medical practitioner and a patient via two-way communication), (b) virtual check-in (a brief 5-10 minute check-in with a medical practitioner via telephone or telecommunication to decide whether an office visit is necessary), and (3) e-visits (a communication between a patient and medical

practitioner through an online patient portal). The three (3) foregoing services will be performed consistent with guidelines published by the Centers for Medicare & Medicaid Services ("CMS") in order to be covered (FACT SHEET March 17, 2020).

28. **Emergency Services and Treatment**. Effective January 1, 2022, emergency services (as defined in the Definitions section) will be covered:

(i) without prior authorization regardless of whether received in-network or out-of-network;

(ii) without regard as to whether provider furnishing the emergency service is a contract provider or a contract emergency facility, as applicable, with respect to the services,

(iii) without conditions such as denials based on final diagnosis codes,

(iv) without regard to any other term or condition of the plan or health insurance coverage other than the exclusion or coordination of benefits, any permissible waiting periods or applicable cost-sharing requirements,

(v) without administrative requirements or limitations that are more restrictive than those applied to in-network emergency services and facilities,

(vi) Any cost-sharing for out-of-network emergency items and services will not be greater than the in-network cost sharing amount that would apply had the items and services been provided by a participating provider or participating emergency facility,

(vii) Any cost-sharing payments made by the participant or dependent will count towards the Plan's applicable deductible and out-of-pocket maximums as if the items and services were provided by a participating provider or participating emergency facility.

The Out-of-Network rate payable for Non-preferred provider emergency services will be determined per the No Surprise Act (Public Law 116-260, Division BB), effective January 1, 2022 under Article XXI, Section H of this booklet).

29. **Non-Emergency Services Provided by Out-of-Network Provider at In-Network Facility.** Effective January 1, 2022, medically necessary non-emergency items, services and visits that are otherwise covered by the Plan (which may include equipment, devices, telemedicine, imaging services, lab work, preoperative and postoperative services) performed by a non-contract provider at in-network facilities (for which the participant or dependent has not knowingly and voluntarily provided consent pursuant to the No Surprise act patient consent and notice requirements) are covered by the Plan as follows:

(i) cost-sharing will not be greater than the in-network cost sharing amount that would apply if the non-emergency items and services had been provided by a contract provider,

(ii) Any cost-sharing payments made by the participant or dependent will count towards, if any, the Plan's applicable deductible and out-of-pocket maximums as if the non-emergency items and services were provided by a contract provider, and

(ii) **Non-emergency Health Care Facilities** include hospitals (as defined in the Social Security Act Section 1861(e)), hospital outpatient department, critical access hospitals (as defined in the Social Security Act section 1861(mm)(1)) and ambulatory surgical centers (as defined in the Social Security Act Section 1833(i)(1)(A)).

The Out-of-Network rate payable for Non-emergency services provided by non-preferred provider at preferred provider facility will be determined per the No Surprise Act (Public Law 116-260, Division BB), effective January 1, 2022 under Article XXI, Section H of this booklet).

Participants and dependents can knowingly and voluntarily agree to be balance billed including waiving the protections that limit cost-sharing for non-emergency services and post-stabilization services provided the following informed patient consent and notice requirements under CAA Section 2799B-2(d) are met:

(i) Notice and consent must be provided together and be physically separate from any other documents by Provider/Facility;
(ii) Must be provided at least 72 hours prior to the scheduled appointment, or if same day no later than 3 hours prior to appointment.
(iii) Notice and consent must list provider's name, good faith estimate for items or services reasonably expected to be provided, statement that patient is not required to consent (and may instead seek care from an available participating provider/facility and in-network cost sharing will apply in such cases), and must be available in 15 most common languages in the geographic region.
(iv) Copy of signed consent must be provided to patient (via in-person or through mail or email) method selected by patient.

However, providers/facilities cannot ask participants and dependents to give up protections not to be balance billed for:

(i) Emergency services;
(ii) Air ambulance services;
(iii) Ancillary services at in-network hospital or ambulatory surgical center, such as emergency medicine, anesthesiology, pathology, radiology, neonatology, assistant surgeon care, hospitalists, intensivists and diagnostic care such as radiology and lab work; and
(iv) Non-emergency services, if no in-network provider is available or unforeseen urgent medical need or provider furnishes ancillary services that the patient typically does not select.

L. Exclusions & Non-Covered Medical and Prescription Drug Benefits

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 126 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 unless determined to be medically necessary by a licensed physician and pursuant to the Plan rules relating to covered transgender benefits.

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.

ARTICLE VII: UTILIZATION REVIEW PROGRAM, PERSONAL CASE MANAGEMENT SERVICES, AND DISEASE MANAGEMENT PROGRAM

A. Utilization Review Program

Utilization Review is a program that reviews the Medical Necessity and quality of Inpatient stays for hospitalization, Substance Abuse, Behavioral Health, and Mental Health services and treatment provided through the Plan. This program is provided by contract with Anthem Blue Cross for medically-related hospitalization and by contract with Optum Health for Substance Abuse and Mental Health 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, Behavioral Health, and Mental Health, is only for the purpose of reviewing whether the admission is necessary for the care and treatment of an Illness or Injury. Whether a service or treatment qualifies as Medical Necessity doesn't mean the service is paid for or covered. It does not guarantee that all charges are covered by the Plan. There are some exclusions, limitations and other conditions that are part of your benefits through 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.

B. 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.

C. 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, Behavioral Health, and Mental Health.

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.

D. Concurrent Review

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

E. 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.

F. Hospital Discharge Planning

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

G. 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.

H. 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.

ARTICLE VIII: SUPPLEMENTAL ACCIDENT BENEFIT

A. Eligibility for 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 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.

B. Maximum Benefit

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

C. Eligible Expenses

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).

ARTICLE IX: MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS

A. Self-funded Indemnity PPO Plan & Kaiser Mental Health Schedule of Benefits

Mental Health benefits are available if You are covered under the Self-Funded Medical Indemnity PPO Plan through Optum Health Behavioral Solutions. Kaiser Permanente Plan members receive Mental Health benefits from Kaiser Permanente. Kaiser participants please refer to your Kaiser Evidence of Coverage Booklet for more information on mental health benefits.

OPTUM HEALTH BEHAVIORAL SOLUTIONS 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 100%.	Plan pays 80% of Usual, Customary and Reasonable Charges after calendar-year Deductible is applied.
Mental / Behavioral Health Outpatient Services	$5 copay per visit.	Plan pays 80% of Usual, Customary and Reasonable Charges after calendar-year Deductible is applied.

IMPORTANT: All PPO benefits for covered mental health behavioral services must go through Optum Health Behavioral Solutions.

KAISER HMO PLAN MEMBER BENEFITS		
	In-Network	**Out-Of-Network**
Calendar Year Deductible	None	None
Calendar-Year Out-of-Pocket Maximum	$1,500 per person, up to $3,000 per family	Not Covered
Mental / Behavioral Health Inpatient Services	$100/admission	Not Covered
Mental / Behavioral Health Outpatient Services	$15 per individual visit, $7 per group visit. No charge for other outpatient services.	Not Covered

B. How to Use the Self-Funded PPO Program

For the Self-funded Plan option, preauthorization is required for all Mental Health and Substance Abuse benefits except in an emergency. You must obtain prior authorization through Optum Health Behavioral Solutions or benefits will not be covered. Optum Health Behavioral Solutions can be reached at 1-877-225-2267.

C. Self-Funded PPO Indemnity Plan & Kaiser Substance Abuse Schedule of Benefits

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

"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.

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

OPTUM HEALTH BEHAVIORAL SOLUTIONS 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 100%.	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.

IMPORTANT: All PPO benefits for covered substance abuse disorder services must go through Optum Health Behavioral Solutions.

KAISER HMO PLAN MEMBER BENEFITS		
	In-Network	**Out-Of-Network**
Calendar Year Deductible	None	None
Calendar-Year Out-of-Pocket Maximum	$1,500 per person, up to $3,000 per family	Not Covered
Substance Abuse Disorder Inpatient Services	$100/admission	Not Covered
Substance Abuse Disorder Outpatient Services	$15 per individual visit, $5 per group visit. $5 per day for other outpatient services.	Not Covered

ARTICLE X: MEMBER ASSISTANCE PROGRAM (MAP) BENEFITS

A. General Information

Member Assistance Program (MAP) benefits are available if You are covered under the Self-Funded Medical Indemnity PPO Plan or the Kaiser Permanente Plan. Member Assistance Program benefits are provided through a separate contract with Optum Health. The MAP program is considered an excepted benefit and is a separate program from the mental health and substance abuse benefits offered through the Self-funded Medical Indemnity PPO Plan or insured medical coverage with Kaiser. You are not required to use or exhaust your MAP benefits before you are eligible for the Plan's medical benefits.

The MAP (a.k.a Employee Assistance Program) 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. No employee copayments, co-insurance or deductible payments are required for participating in the MAP program. This is because the Plan pays a premium to Optum for the MAP services. However, if you desire additional services not covered by the MAP or choose a practitioner who is not part of Optum's network, you will be responsible for any such payment.

B. 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?

FOR MORE DETAILS ON WHAT THE MAP COVERS AND LIMITATIONS INCLUDING EXCLUSION PLEASE REFER TO THE MAP EVIDENCE OF COVERAGE BOOKLET.

ARTICLE XI: 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, prescription drug benefits are provided by the Kaiser Permanente Plan. Please refer to the Kaiser Permanente Evidence of Coverage booklet or Summary of Benefits and Coverages for more information.

Prescription drug benefits are provided in cooperation with MaxorPlus. Information concerning prescription drug benefits, including a list of the pharmacies in the MaxorPlus retail pharmacy network, can be obtained by calling MaxorPlustoll-free at 1-800-687-0707. Additional information concerning prescription drug benefits can be obtained at the MaxorPlus website, www.maxorplus.com.

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

A. 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.

B. Prescription Drug Options

There are two options for obtaining Your prescription drugs:

1. MaxorPlus retail pharmacy network (up to 90-day supply)

2. MXP Mail Order pharmacy for prescription drugs (90-day supply)

Each option is discussed below.

C. MaxorPlus Retail Pharmacy Network

You can purchase up to a 90-day supply of a prescription drug from a pharmacy in the MaxorPlus retail pharmacy network by paying the applicable copayment. You may call MaxorPlus toll-free at 1-800-687-0707 or go on the web at ***www.maxorplus.com*** for a list of pharmacies in the MaxorPlus 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 MaxorPlus Retail Pharmacy network, do the following:

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

2. Pay the copayment amount.

D. 90-Day Supply of Prescription Drugs from MXP Mail Order Pharmacy

You can purchase a 90-day supply of many prescription drugs from MXP Mail order pharmacy.
How to Order by Mail

- Go online and activate your mail order account at www.maxorplus.com.
- Fill out the MAIL ORDER FORM that is available on the website, and mail it to the pharmacy, along with your prescription and payment. You may also contact Member Services to have a MAIL ORDER FORM mailed to your address of choice.
- Call us toll-free at 800-687-8629 and speak to a Member Advocate who will help you activate your mail order account

  MXP Pharmacy
  PO Box 32050
  Amarillo, Texas 79120-2050

Refills

- **You may refill your prescriptions on our website at www.maxorplus.com once you have registered. Please chose the MAXOR PHARMACY REFILLS tile.**
- Members can call 800-687-8629 and follow the menu instructions to refill medications or to speak with a Member Advocate about refills.
- You may print a MAIL ORDER FORM from the MaxorPlus website and mail it to the pharmacy, along with your prescription and payment. Please include a check, money order, or fill out the credit/debit card section on the form. Our mailing address is: MXP Pharmacy, PO Box 32050, Amarillo, Texas 79120-2050.

The earliest refill date is printed at the bottom of your prescription bottle.
Note: You may be asked for your prescription number when discussing refills. It is a number, beginning with a 92, found at the top left corner of your prescription bottle. The prescription number will remain the same until your refills run out

Prescription Delivery

- Your medications are generally delivered via first-class mail by the US Postal Service.
- We offer expedited shipping through UPS or FedEx for an additional fee. **Please note that UPS or FedEx**
  requires a physical address and will not deliver to PO Boxes.
- Refrigerated medications, such as insulin, are shipped UPS or FedEx overnight at no additional cost to you.
- You should receive your medication within five business days from the time MXP Pharmacy receives and
  processes your prescription. Note: It may take longer to receive your order if a prescription requires intervention (i.e. prior authorization).
- If your prescription claim rejects at MXP Pharmacy due to a prior authorization, we will obtain the necessary information to process the request and reach out to you if needed. Typically, this process takes 24-48 hours, depending on how quickly the required information is obtained from your physician If you have any questions regarding the status of a prior authorization request, please call MaxorPlus Member Services at 800-687-0707.

Payment

- If an online mail order account has been activated, the credit/debit card saved securely will be used to process payments on new and existing refill prescriptions.

- If you are mailing in your prescriptions, you can send a check, money order, or credit/debit card information along with your MAIL ORDER FORM. Orders cannot be processed without payment.
- Contact MXP Pharmacy Member Services at 800-687-8629 to add or update your credit card information. Please note that orders cannot be processed without payment.

E. Summary of Payment Obligations

MaxorPlus 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

F. Specialty Pharmacy Program for Certain Prescription Drugs

Certain prescription drugs used for treating complex health conditions **MUST** be obtained from the **Maxor 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 Maxor 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 Maxor Specialty Pharmacy and to obtain a prescription drug that must be obtained from the Maxor Specialty Pharmacy, call Maxor Specialty Pharmacy toll-free: 1-866-629-6779. A Maxor Specialty clinical staff specialist will begin the process by verifying eligibility and coverage of the requested medication. When calling Maxor Specialty, identify Yourself as an IBEW / NECA Sound and Communications Health and Welfare Trust participant. The 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		
	Network Provider	**Non-Network Provider**
Copayment for Specialty Prescription Drugs	20% of the drug cost –up to a $150 maximum	Not Covered

G. 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” (DAW) 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. DAW differentials are not applied to the maximum out-of-pocket.

H. 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.

I. Clinical Prior Authorization

Prior authorizations are approved, based upon pre-defined criteria developed by the MaxorPlus Clinical Advisory Board. MaxorPlus clinicians develop these criteria through a combination of current medical literature, manufacturer information, and current practice guidelines for the various disease states and products under review. Numerous factors are always taken into consideration when evaluating PA criteria for individual members, including other therapies being taken by the patient, appropriateness of the drug for the patient’s condition, previous utilization, clinical studies, and medical journals.

ARTICLE XII: DENTAL BENEFITS

A. Preferred Provider Dental Organization

The Plan has entered into a separate agreement with Anthem Blue Cross Dental PPO, a Preferred Provider Dental Organization (PPDO). Dental benefits through the Plan are self-funded. You can qualify for substantial savings on dental services offered by the Plan’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 Plan 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 – Anthem Blue Cross Dental PPO
Anthem Blue Cross Dental PPDO network is available throughout California.

Any time You need to see a Dental Provider, consult the Anthem Blue Cross PPDO Network Directory for a list of Dental Providers that are members of the Anthem Blue Cross 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 Anthem Blue Cross website:

1. Go to www.Anthem.com
2. Click on the Individual and Family
3. Click on "Find a Doctor"
4. Scroll down to "Search as a Guest" and Click on "Continue"
5. ***How you get insurance?*** - Through your employer
6. ***State?*** Your State
7. ***Type of Care?*** - Dental
8. ***Select a Plan?*** - Dental Blue 100/200/300
9. You can just enter your zip code and change the mileage span to 5 miles.

You can also contact Anthem Blue Cross by telephone toll-free at 1-800-688-3828, Monday through Friday.

B. Dental Benefits & Eligibility

Participants and Dependents must meet the eligibility rules described in this booklet and any subsequent changes to the eligibility rules to qualify for benefits under the Plan.

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

C. Percentage the Plan Pays

Class I – Diagnostic and Preventative Services	100% of UCR Charges or Anthem Blue Cross Contracted Fee up to Maximum
Class II – Basic Services	80% of UCR* Charges or Anthem Blue Cross Contracted

	Fee up to Maximum
Class III – Major Services	After Deductible, 60% of UCR* Charges or Anthem Blue Cross Contracted Fee up to Maximum
Orthodontics	After Deductible, 60% of UCR* Charges or Anthem Blue Cross Contracted Fee up to Maximum

***** Usual, Customary and Reasonable

D. 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.

D. Covered Dental Charges

Dental expenses must be incurred for dental procedures necessary to Participant's and eligible Dependent's 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 in this section. Covered dental expenses include:

Class I – Diagnostic and Preventative Services

- Effective August 1, 2018, Routine oral examinations including prophylaxis, cleaning, scaling, and polishing, up to two (2) examinations in a calendar year.
- Effective August 1, 2018, Topical fluoride applications, up to two (2) in a calendar year; for dependent children who have not attained age 15, up to four (4) in a calendar year.
- 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. Extractions for overcrowding is covered under the Orthodontic Benefit.
- 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.
- On lays 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.

Personal Protective Equipment (During Public Health Emergency Period)

Effective June 1, 2020 and during the period of the declared public health emergency, the Plan will temporarily cover Personal Protective Equipment incurred for medically necessary dental procedures for eligible Participant's and Dependent's performed by or under the direct supervision of a dentist and will only be reimbursed up to a **maximum of $50.00** only for network and non-network dental providers.

Teledentistry Charges (During Public Health Emergency Period)

Effective June 1, 2020 and during the period of the declared public health emergency, the Plan will temporarily cover teledentistry coverage for medically necessary dental services or items subject to current Plan provisions relating to reimbursement of in-network and out-of-network providers, and will only be reimbursed up to a **maximum of $25.00.** This means teledentistry charges with a covered dental provider and the following virtual services provided by a dental provider: (a) teledentistry visits (a visit between a dental practitioner and a patient via two-way communication), (b) virtual check-in (a brief 5 to 10 minute check-in with dental practitioner via telephone or telecommunication to decide whether an office visit is necessary), and (3) e-visits (a communication between a patient and dental practitioner through an online patient portal).

F. 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 a calendar year.

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 stay plate 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.

G. Temporomandibular Joint Syndrome (TMJ)

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

H. 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.

ARTICLE XIII: VISION BENEFITS

The vision benefits are available if You are covered under the Self-Funded Medical Indemnity PPO Plan or the Kaiser Permanente Plan. The vision benefits are provided through an insured 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.

A. Vision Benefits

1. **Exam:** You and your Dependent Spouse including child(ren) are entitled to a comprehensive eye exam to determine the presence of vision problems or other abnormalities. Services shall be provided once every 12 (twelve) months for adults, dependent children over age 19 and dependent children under age 19.

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 under age 19 are covered in full when dispensed by a VSP network Provider. The Plan covers lenses once every 12 (twelve) months for adults and all dependent children.

3. **Frame:** VSP covers a frame allowance of up to $150 for in-network and up to $70 for out-of-network. The frame benefit provides You the choice to select a frame that fits Your lifestyle. Have Your Doctor help You choose the best frame for You, based on Your VSP coverage. The Plan covers frames once every 12 (twelve) months for adults and dependentchildren over age 19 and dependent children under age 19 after applicable copay.. 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 $150 and medically necessary contact lenses are covered in full in-network every 12 months. 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 up to $60 copay. Contact lenses are in lieu of all other benefits (exam, lenses and frames) for that eligibility period. Copays do not apply.

   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).

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 Well Vision Exam, or get 20% off from any VSP Doctor within 12 months of Your last Well Vision Exam.
   - Save on eyewear and eye care when you see a VSP network doctor. Take advantage of Exclusive member extras for additional savings.

6. **Retinal Screening:** Guaranteed in network member pricing of $39. as an enhancement to Your Well Vision 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 Vision Care 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. Average 15% off the regular price or 5% off the promotional price. Discounts on LASIK, Custom LASIK, and PRK, plus patient education Wavefront technology with the microkeratome surgical device only. Discounts are only available from VSP contracted facilities. Other LASIK procedures performed at additional cost. Details about VSP's Laser Vision Care 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 instead of a pair of prescription glasses or contacts from their VSP Provider.

B. 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:

	FREQUENCY	IN-NETWORK COVERAGE
Well Vision Exam	• *Focuses on your eyes and overall wellness* • *Every 12 months*	$10 Copay Adults and Children Over Age 19. No Charge Children under Age 19.
Prescription Glasses		$25 Copay Adults and Children Over Age 19.

		No Charge Children under Age 19.
FRAME	*Every 12 months (retail allowance)*	**Adults and Children over Age 19 and Children Under Age 19** • $150 frame allowance • $170 featured frame brands allowance • 20% savings on the amount over your allowance
LENSES		
Glass or plastic, Single Vision, Lined Bifocal and Lined Trifocal Lenses or Lenticular	*Every 12 months*	**Adults and Children over Age 19 and Children Under Age 19** Included in Prescription Glasses
LENS ENHANCEMENTS		
Impact-resistant Lenses	*Every 12 months*	Covered in Full for Children under age 19 only. 40% average savings for Adults and Children over 19
Scratch-Resistant Coating and UV Coating		Covered in Full for Children under age 19 only. 40% average savings for Adults and Children over 19
		40% average savings for Adults and Children over 19
		40% average savings for Adults and Children over 19
Standard Progressives		No Charge (Adults and All Dependent Children)
Premium Progressives		$80-$90 Adults & All Dependent Children
Custom Progressives		$120- $160 Adults & All Dependent Children
CONTACTS (INSTEAD OF GLASSES)		
Contacts (in lieu of glasses) Contact Lens Exam (fitting and evaluation) Medically Necessary Contacts	*Every 12 months*	$150 allowance copay does not apply (Adults & All Dependent Children) Covered in full after copay after not to exceed $60 copay (Adults & All Dependent Children). 15% off contact lens exam services at VSP doctors only. Covered in full after $25 copay
DIABETIC EYECARE PLUS PROGRAM		
Retinal Screening for members with Diabetes	*As needed*	No Charge (Adults and All Dependent Children)
Additional exams and services for diabetic eye disease, glaucoma, or age-related macular degeneration.	*Limitations and coordination with your medical coverage may apply. Ask VSP doctor for details*	$20 per exam (Adults and All Dependent Children)

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.

C. 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.

D. 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.

E. 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.

F. Out-Of-Network Reimbursement Schedule

Maximum Reimbursement for services from an Out-Of-Network Provider**.** Please call member services for out-of-network plan details. Copays still apply.

OPEN ACCESS SCHEDULE (OUT-OF-NETWORK)

PROFESSIONAL FEES- $10 copay for Adults and Children over 19, $0 copay for Dependent Children under 19	
Exam	Up to $50 Adult & All Dependent Children

MATERIALS - $25 copay Adults and Children over 19; $0 copay for Dependent Children under 19	
Single Vision Lenses	Up to $ 50 (Adult & All Dependent Children)
Bifocal Lenses	Up to $ 75 (Adult & All Dependent Children)
Trifocal Lenses	Up to $100 (Adult & All Dependent Children)
Lenticular Lenses	Up to $125 (Adult & All Dependent Children)
Progressive Lenses	Up to $75 (Adult & All Dependent Children)
Frame	Up to $70 (Adult & All Dependent Children)

CONTACT LENSES *	
Elective contact lenses and contact lens (fitting and evaluation) exam	Up to $105 (Adult & All Dependent Children)
Medically Necessary contact lenses	Up to $210 after $25 copay (Adult & All Dependent Children)

***** 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.

G. 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.

H. 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 www.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. There is No copay for Dependent Children (ages newborn to 19). Adult Dependent children (ages 19 to 26) are subject to the same applicable copayment as Adults. 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. However, if you decide to use the services of a Doctor who is not a VSP network Doctor, you should pay the doctor his or her fee.

I. 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:

(a) 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**

(b) 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.

J. 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 the address below or may be filed online at www.vsp.com :

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

K. 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 Customer Services Department's toll-free number at 1-800-877-7195 Monday through Friday, 5:00 AM – 8:00 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. If you are dissatisfied with the results after exhausting VSP's grievance procedures, you may file written appeal with the Plan's Board of Trustees, as provided in the Claims and Appeals Procedures section of this booklet.

The California Department of Managed Health Care ("Department") is responsible for regulating health care service plans and receiving complaints regarding VSP (and similar programs). If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by VSP, you may call the Department's help center toll-free at 800-466-2219. The hearing and speech impaired may use the California Relay Service's toll-free telephone number 1-877-688- 9891 (TDD) to contact the Department. Health plan complaint forms and instructions are available online at the Department's website, ***http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_complaint.aspx.***

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. **NOTE:** 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.

L. 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.

M. 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.

N. 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).

ARTICLE XIV: LIFE INSURANCE BENEFITS

FOR CATEGORY 1 (BARGAINING UNIT) & CATEGORY 2 (NON-BARGAINING UNIT) EMPLOYEES

Life insurance benefits are available to Category 1 (bargaining unit) Employees and Category 2 (subscription agreement employees). An employee who does not qualify for insurance under the Plan, 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.

A. Amount of Insurance

The Plan provides $15,000 of life insurance coverage per eligible Category 1 bargaining unit employee and Category 2 non-bargaining unit employee.

B. 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

C. 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.

D. 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 Plan;

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).

E. Waiver of Premium If Totally Disabled

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.

F. 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.

G. 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:

b. You may not convert insurance which has been in effect for less than five years.

c. 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**.

H. 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.

I. 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.

J. 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.

K. 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.

L. Assignment

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

M. 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

ARTICLE XV: ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE BENEFITS

FOR CATEGORY 1 (BARGAINING UNIT) & CATEGORY 2 (NON-BARGAINING UNIT) EMPLOYEES

Accidental Death and Dismemberment (AD&D) insurance benefits are available to Category 1 (bargaining unit) Employees and Category 2 (subscription agreement employees). An employee who does not qualify for insurance under the Plan, 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.

A. 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).

B. 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.

C. Assignment

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

D. 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.

E. 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.

F. 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.

G. 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

ARTICLE XVI: 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's assets. Category 2 (subscription agreement employees) are not eligible for short-term disability benefits.

A. Establishing and Maintaining Eligibility

Short Term Disability (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 Plan 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.

B. Eligibility for Benefits

Eligible Employees are entitled to receive STD benefits if they are: (1) Totally Disabled as a result of a non-occupational accidental Injury or sickness, (2) have met any waiting period and (3) have submitted all required documentation to the Trust Administrative Office.

C. 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.

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

I. Exclusions and Limitations on STD Benefits

STD benefits for otherwise eligible Employees <u>are not available or will be terminated</u> 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.

J. 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.

K. 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.

ARTICLE XVII: 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.

A. HRA Eligibility

Active Participant Eligibility. You are eligible to participate in the HRA Plan if You work under a Collective Bargaining Agreement that allows for Contributions to an HRA on Your behalf and You must be actually enrolled in the IBEW/NECA sound and communications health and welfare Plan or other group health coverage that provides minimum value pursuant to the Internal Revenue Code Section 36B(c)(2)(C)(ii). Proof of other group health coverage will be required in a manner to be determined by the Board of Trustees. If you do not provide proof of enrollment in another group health coverage that provides minimum value, in a manner determined by the Board of Trustees, benefits from your HRA account will be limited to reimbursement of co-payments, deductibles, and premiums, as well as medical care as defined under the Internal Revenue Code Section 213(d) that does not constitute essential health benefits. If You have an HRA account balance you are **permitted to** permanently opt out of and waive future reimbursements from your HRA account at least annually. Upon termination of employment, You **may** elect to either: (1) forfeit your HRA account balance or (2) permanently opt out of and waive future reimbursements from your HRA account. **NOTE: Non-Bargaining unit Employees are not eligible for an HRA account.**

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.

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).

Retiree Health and Welfare Payments. Since there is no retiree health and welfare coverage through the Plan once an active participant retires the HRA was established for the purposes of defraying the cost of medical expenses when you retire (ex. COBRA premiums, Medicare Parts A, B and D premiums). You are eligible to participate in the HRA Plan if You worked under a Collective Bargaining Agreement that allowed for contributions to an HRA on Your behalf prior to your retirement and you are actually enrolled in the IBEW/NECA sound and communications health and welfare Plan or other group health coverage that provides minimum value pursuant to the Internal Revenue Code Section 36B(c)(2)(C)(ii). **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**. If you are entitled to Medicare, the Plan will coordinate benefits with Medicare pursuant to the Plan's coordination of benefits rule. Please refer to Article XIX of this booklet for more information.

Upon Participant Death. In the event of Your death, Your surviving spouse and Dependent children will continue to be eligible for reimbursement of eligible expenses from Your HRA account provided they were previously covered as eligible Dependents under the Plan 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).

However, if You have no medical qualified Dependent upon Your death, Your HRA account balance will revert to the general assets of the Trust.

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.

B. 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 eligible spouse, and/or Your eligible Dependents.

NO CASH BENEFIT. 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 unless permitted by the IRC or lawful regulations issued thereunder. Payments will only be made to You, or to Your Beneficiary in the event of Your death.

NO ASSIGNMENT TO PROVIDERS. There is no assignment of benefits to Providers and no benefit payments may be paid to Providers.

C. 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 five 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 five 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. If there has been no activity or contributions to your HRA for five (5) years, any unused account balance will be moved to a suspension account and if activity resumes, your unused HRA will be reinstated.

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: (1) Your HRA account reaches a zero balance, (2) the HRA ends, or (3) five 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: (1) date they no longer meet the Plan's definition of Dependent, (2) the date Your HRA account reaches

a zero balance, or (3) 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.

D. Reimbursable Expenses

You can use the money in Your HRA to pay for **qualified 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, qualified 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 Qualified 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.
- 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.
- 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.

Effective for expenses incurred on or after January 1, 2020, qualifying medical expenses reimbursable under the HRA pursuant to the Internal Revenue Code, include the following:

- Over-the-counter (OTC) medicines and drugs without a prescription and
- Menstrual care products (defined as tampons, pads, liners, cups, sponges and similar products used by the individual with respect to menstruation or other genital-tract secretions.).

E. Expenses Not Eligible for Reimbursement

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

- Premiums or expense reimbursements for individual market coverage or individual coverage purchased from the public or private health insurance exchange.
- 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.
- 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.

F. Claim and Reimbursement Procedures

The Plan has contracted with Navia Benefit Solutions to help administer the reimbursements of eligible HRA expenses. Navia issues members a debit card to use in the alternative of submitting a claim for reimbursement. The Navia debit cards can only be used for eligible qualified expenses. IRS regulations require that all debit card transactions are substantiated and that improper use of the card will result in suspension of card privileges. If You, Your spouse, and/or Your Dependents are eligible for other group health coverage, You must include a copy of the Explanation of Benefits (EOB) from the other group health 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 but any written claim form must be submitted timely (see paragraph below). 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.

Timely Submission of Proof of Claim. To receive reimbursement for eligible expenses, You must submit a written claim form (with supporting documents) 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.

If you are using the Navia debit card you can access your HRA in three ways:

1. **Online Claim Submission Tool.** If you paid out of pocket and are requesting reimbursement you can use the Navia Online Claim submission tool at https://www.naviabenefits.com.
2. **MyNavia App.** You can use the MyNaviaApp to submit claims right through your mobile phone. Just enter your claim information and upload a photo of your documentation from your phone's camera.
3. **Email.** Fill out a claim form, attached your itemized documentation and then email it to claims@naviabenefits.com.

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.

G. Claim Submission

Please e-mail your claims to claims@naviabenefits.com OR mail your completed claim form and any required documentation to:

Navia Benefit Solutions
IBEW / NECA Sound and Communications Health and Welfare Trust
ATTN: HRA Claims Dept.
P.O. Box 53250
Bellevue, WA 98015

Note: The HRA is intended to qualify as a medical reimbursement plan under Internal Revenue 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).

H. Claims and Appeal Rights

The same claims and appeals rights in the major Plan applies to any HRA claim denials and requests for review. Please refer to the Claims and Appeals section of this booklet.

I. Benefits Are Not Vested

The Board of Trustees may amend, reduce, eliminate or otherwise change the HRA Plan at any time and may change, reduce or discontinue any Plan benefits, in whole or in part, at any time. The Board of Trustees may also change the HRA eligibility requirements and any other Plan rules at any time.

ARTICLE XVIII: ADMINISTRATION OF THE PLAN AND CLAIMS & 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

Street Address
6800 Santa Teresa Blvd., Suite 100
San Jose, CA 95119

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

If You have any questions regarding the Plan, please contact United Administrative Services. The claims and appeals procedures set forth below apply only for non-fully insured and non-HMO Benefits (ex. the self-funded benefits). Claims and appeals for insured (ex. VSP) and HMO benefits (ex. Kaiser) are governed by the rules of the specific insurance companies and HMO, which are available upon request from the applicable insurance carrier or HMO.

A. Claims For Benefits (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 to United Administrative Services or on the website 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 Kaiser Permanente enrollees, present Your ID card at Your Kaiser Permanente facility for services and prescription drugs.
4. For enrollees under the Self-Funded Indemnity Medical Plan please obtain a claim form by calling or writing to the Trust Fund Office or visiting the website at **www.soundcommbenefits.com**.

B. 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.

3. External Review of Certain No Surprises Act Claims (CAA Section 110).

This External Review process is intended to comply with the No surprises Act external review requirements. The Plan will comply with an applicable external review process, as described in 26 CFR 54.9815-2719(d), 29 CFR 2590.715-2719(d), and 45 CFR 147.136(d) and any subsequent implementing regulations. As such, eligible participants and dependents have the right to request external review after he/she has exhausted the Plan's current internal claims and appeals rules, upon receipt of an adverse benefit determination as it relates to whether the Plan is complying with the surprise billing and cost-sharing protections under the No Surprises Act and its implementing regulations for certain No Surprise Act claims and services mentioned in this section. This means that, generally, you may only seek external review after a final determination has been made on your appeal. **External Review is available only with respect to the following types of claims (whether urgent, concurrent, pre-service or post-service claim is denied**):

(1) out-of-network emergency services,
(2) non-emergency services provided by a non-network provider at an in-network facility and
(3) out-of-network air ambulance services.

External review is permitted only in certain cases for adverse benefit determinations (including a final internal adverse benefit determination) by the plan or insurer that involves medical judgment, including but not limited to, those based on the plan's or insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, as well as a consideration of whether the plan or insurer is complying with the surprise billing and cost sharing protections under ERISA sections 716 and 717 and §§ 2590.716-4 through 2590.716-5 and 2590.717-1.

To illustrate, the scope of claims eligible for external review include:

(i) Whether a particular item or service constitutes treatment for emergency services.
(ii) Whether services provided by an out-of-network provider at in in-network facility is subject to the No Surprise Act.
(iii) Whether an individual was in a condition to receive Patient protection notice under the No Surprise Act and able to waive the right to those protections.
(iv) Whether a provider has coded the claim correctly, consistent with the treatment the patient actually received.
(v) Whether cost-sharing was appropriately calculated for claims for ancillary services provided by an out-of-network provider at an in-network facility.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

<u>There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Care Claims.</u>

(1) External Review of Standard Claims

a. Your request for external review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of an Claim Appeal Benefit Determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

b. Within five (5) business days of the Plan's receipt of your request for an external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

(i) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(ii) The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan.

(iii) You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

(iv) You have provided all of the information and forms required to process an external review.

c. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

(i) If your request is complete and eligible for external review; or

(ii) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

(iii) If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

d. Review of Standard Claims by an Independent Review Organization (IRO). If the request is complete and eligible for an external review, the Plan will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

(i) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

(ii) Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

(iii) If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(iv) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria,

medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

(v) The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. [If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

(vi) The assigned IRO's decision notice will contain:

i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

ii. The date that the IRO received the request to conduct the external review and the date of the IRO decision;

iii. References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

iv. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

v. A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

vi. A statement that judicial review may be available to you; and

vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

(2) External Review of Expedited Urgent Care Claims.

a. You may request an expedited external review if: 1) you receive an adverse Initial Claim Appeal Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or 2) you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Claim Appeal Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

b. Preliminary Review for an Expedited Claim. Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

c. Review of Expedited Claim by an Independent Review Organization (IRO). Following the preliminary review that a request is eligible for expedited external review, the Plan will assign an IRO (following the process described under Standard Review above). The Plan will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements set forth above under Standard Claims, as

expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

(i) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(ii) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

C. Payment of Claims

All medical and dental claim payments will be paid according to the rules of the Plan to the Employee unless the claim has been properly 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.

D. 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.

E. Claims Procedure

If You have a claim concerning benefits provided by an Insured carrier such as 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.

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 Section F.

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. <u>Time Limits for Claims Procedure & Denial of a Claim by the Trust Administrative Office.</u>

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.

b. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a claim. However, if a Participant files a claim for specific benefits and the claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a claim.

c. The term “claim” means a request for a benefit made by a participant and/or dependent in accordance with the Plan’s procedures. Claims are categorized as follows:

i. **Pre-Service Claim.** A Pre-Service claim means a claim for benefit which the Plan requires precertification or prior authorization before medical care is obtained in order to receive the maximum benefits allowed under the Plan. If the Plan requires you to obtain advance approval of a non-urgent service, supply, or procedure before a claim will be payable, such a request for prior approval is considered a Pre-Service Claim. You will be notified of the decision not later than 15 days after receipt of the Pre-Service Claim. This time period may be extended up to an additional 15 days due to circumstances beyond the control of the Plan. If an extension is necessary, you will be notified of the extension before the end of the initial 15 or 30-day period. To illustrate, there may be an extension if you have not submitted sufficient information, in which case you will be notified of the information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

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

ii. **Urgent Claim.** The term Urgent Claim means a claim for medical care or treatment that, if normal pre-service standards for rendering a decision were applied would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or in the opinion of a physician with knowledge of the claimant’s medical condition, would subject that claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. For properly filed Urgent claims, the Plan will respond with a determination by telephone as soon as possible, taking into account the medical

emergencies, but not later than 72 hours after receipt of the claim. The determination will also be confirmed in writing. Urgent claims which may include requests for precertification of hospital admissions and prior authorizations must be submitted by fax. Urgent Care claims may not be submitted via the US Postal Service.

If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Plan will notify the Participant as soon as possible, but not later than 24 hours after receipt of the Claim, of the specific information necessary to complete the Claim. The Participant must provide the specified information within two (2) business days. If the information is not provided within that time, the Claim will be denied.

During the period in which the Participant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is suspended from the date of the extension notice until either two (2) business days or the date the claimant responds to the request, whichever is earlier. Notice of the decision will be provided no later than 48 hours after receipt of the specified information or the end of the two (2) business day period given for the Participant to provide this information, whichever is earlier.

If a Participant improperly files an Urgent Claim to the Trust Fund Office, the Trust Fund Office will notify the Participant as soon as possible but not later than 24 hours after receipt of the Claim, of the proper procedures to be followed in filing an Urgent Claim. The Participant will only receive notice of an improperly filed request for prior authorization of an Urgent Claim if the Claim includes (i) the patient's name, (ii) the patient's specific medical condition or symptom, and (iii) the specific treatment, service or product for which approval is requested. Unless refiled properly, it will not constitute a Claim.

iii. **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. If the course of treatment involves urgent care and you request an extension of the course of treatment that is in progress at least 24 hours prior to the expiration of the approved Urgent Claim, you will be notified within 24 hours after receipt of the request.

iv. **Post-Service 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 Post-Service 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 starting on page 89.

2. **Authorized Representatives.** An authorized representative, such as a spouse or an adult child, may submit a Claim on behalf of a Participant if the Participant has previously designated the individual to act on his or her behalf. An Appointment of Authorized Representative form, which may be obtained from the Trust Fund office, must be used to designate an authorized representative. The Trust Fund Office may request additional information to verify that the designated person is authorized to act on the Participant's behalf. A health care professional with knowledge of the Participant's medical condition may act as an authorized representative in connection with an Urgent Claim without the Participant having to complete the Appointment of Authorized Representative form.

3. **Content of Initial Adverse Benefit Determination Notice.**

a. An **Adverse Benefit Determination** is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Such Adverse Benefit Determinations may be based on:

- Payment of less than 100% of a claim for benefits (including coinsurance or copayment amounts of less than 100% and amounts applied to the deductible);
- Results of any utilization review decision;
- Failure to cover an item or service because the Plan considers it to be Experimental, Investigational or not medically necessary;
- Coverage determinations, including Plan limits or exclusions.
- Your eligibility for coverage.

b. 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(s) 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 a statement of Your right to bring a civil lawsuit under ERISA Section 502(a) for the benefit after an adverse determination following an appeal 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

vi. 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

F. Appeals Procedure

4. **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 San Jose, CA 95150-5057	6800 Santa Teresa Blvd., Suite 100 San Jose, CA 95119

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. **Authorized Representatives.** An authorized representative, such as a spouse or an adult child, may submit a Claim on behalf of a Participant if the Participant has previously designated the individual to act on his or her behalf. An Appointment of Authorized Representative form, which may be obtained from the Trust Fund office, must be used to designate an authorized representative. The Trust Fund Office may request additional information to verify that the designated person is authorized to act on the Participant's behalf. A health care professional with knowledge of the Participant's medical condition may act as an authorized representative in connection with an Urgent Claim without the Participant having to complete the Appointment of Authorized Representative form.

d. 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.

e. If You or Your authorized representative request to appear at a hearing (if applicable) 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.

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

5. Appeal 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. Except for reviews of Urgent claims (which a decision will be made as soon as possible but no later than 72 hours of receipt of the appeal by the Trust Fund Office) 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. Under the Plan rules, no lawsuit may be filed **more than 1 (one) year** after services were provided or benefits partially or totally denied or an otherwise adverse benefit determination was made against you. The provision of this section shall apply to and include any and every claim to benefits from the Trust Fund, and any claim or right asserted under the Plan or against the Trust Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a participant or beneficiary of the Plan with the meaning of those terms as defined in 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.

G. Claims & Appeal Procedure for Disability Benefits

This Claims Appeal Procedure is applicable for the denial, reduction or termination of a short-term disability benefit and/or any other benefits that relate to a disability determination.

1. Denial of a 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.

b. A retroactive rescission (meaning cancellation or discontinuance) of your disability benefit coverage will be considered an adverse benefit determination that would trigger the Plan's appeals procedures. However, if the retroactive rescission was due to a failure to timely pay required premiums or contributions toward the cost of coverage that would not be considered an adverse benefit determination.

2. Content of the Disability Claim 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 including an explanation for: (1) disagreeing with the view of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (2) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable); and (3) Explanation for disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);

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 receive upon request and free of charge, reasonable access to and copies of all

relevant documents, records and information to your claim for benefits, 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, standard or other similar criterion, the internal rule, guideline, protocol, standard or similar criterion will be described or provided to You or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;

vi. Statement of your right to present evidence and testimony in support of your claim during the appeal/review process;

vii. Statement that on appeal, you will have the right to respond to the denial if the Plan receives new or additional evidence and you will also be provided, free of charge, with any new or additional evidence considered, as soon as it becomes available to the Plan and sufficiently in advance of the date on which the appeal determination notice is required to be provided to you under the Plan's rules. (This will usually be before the next regularly scheduled meeting of the Board of Trustees unless special circumstances requires a further extension of time); and

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

3. <u>Appeal Procedure to the Board of Trustees.</u>

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	6800 Santa Teresa Blvd., Suite 100
San Jose, CA 95150-5057	San Jose, CA 95119

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.

g. On appeal, you will also have the right to respond to the denial if the Plan receives new or additional evidence and you will also be provided, free of charge, with any new or additional evidence considered, as soon as it becomes available to the Plan and sufficiently in advance of the date on which the appeal determination notice is required to be provided to you under the Plan's rules. (This will usually be before the next regularly scheduled meeting of the Board of Trustees unless special circumstances requires a further extension of time).

4. <u>Decision by the Board of Trustees.</u>

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.

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

i. The specific reason(s) for the decision including an explanation for: (1) disagreeing with the view of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (2) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable); and (3) Explanation for disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);

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 including any Plan imposed timeline for filing a lawsuit and the expiration date for bringing suit;

v. A statement that if the decision is based on an internal rule, guideline, protocol, standard or other similar criterion, the internal rule, guideline, protocol, standard or similar criterion will be described or provided to You or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;

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

d. 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. Under the Plan rules, no lawsuit may be filed **more than 1 (one) year** after services were provided or benefits partially or totally denied or an otherwise adverse benefit determination was made against you. The provision of this section shall apply to and include any and every claim to benefits from the Trust Fund, and any claim or right asserted under the Plan or against the Trust Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a participant or beneficiary of the Plan with the meaning of those terms as defined in ERISA. However, if the Plan has failed to comply with the claims and appeals procedure requirements for disability claims, you will not be prohibited from filing suit or seeking court review of a claim denial based on a failure to exhaust the administrative remedies under the Plan unless the violation was the result of a minor error or considered "de minimis." This would mean: (a) non-prejudicial, (b) attributable to good cause or matters beyond the Plan's control, (c) in the context of an ongoing good-faith exchange of information, (d) and not reflective of a pattern or practice of non-compliance by the Plan.

e. 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.

H. External Review (For Kaiser HMO Enrollees)

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

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

If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review ("IMR") process managed by the California Department of Managed Health Care (DMHC). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you

decide not to request an IMR, you may give up the right to pursue some legal actions against Kaiser. You may qualify for IMR if all of the following are true:

- One of these situations applies to you:
  a) you have a recommendation from a provider requesting Medically Necessary Services
  b) you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
  c) you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary.
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission.

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

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

ARTICLE XIX: COORDINATION OF MEDICAL BENEFITS (COB)

Generally, 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 lawful 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. Coordination of benefits also help control costs.

A. 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, Mental Health/Substance Abuse Disorder, Prescription Drug, Dental, and Vision Benefits:

1. Group or blanket insurance (except student accident insurance);

2. Group Anthem Blue Cross and other pre-payment coverage on a group basis, including HMOs (ex. Kaiser);

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.

B. Coordination of Benefits General Rule

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.

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

C. 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.

If other Plan does not have COB provision. When another Plan does not have a COB provision, that Plan is the Primary Plan.

If other Plan does have COB provision. 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) on page 99 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.

Coordination with Medicare. Medicare coordination of benefits rules applies with the participant or dependent has coverage under this Plan and is eligible for insurance under Medicare Parts A and B (whether or not the insured person has applied or is enrolled in Medicare).

1. Coverage under any medical plans offered will be secondary if you are eligible for Medicare and you are a Retired Participant or a Dependent of Retired participant.

2. ***For You.*** Medical coverage under this Plan (including the HRA) will be primary if you are eligible for Medicare because of age 65 or disability (other than End Stage Renal Disease) and you are covered under the Plan because you are still actively performing covered employment. The Plan (and HRA) will be secondary if (i) you are eligible for Medicare and the above conditions do not apply or (ii) the Plan is legally permitted to pay second.

3. ***For Your Dependent.*** Medical coverage under this Plan (including the HRA) will be primary if your dependent spouse is eligible for Medicare because of age or disability (other than End Stage Renal Disease) and you are covered under the Plan because you are still actively performing covered employment. The Plan (and HRA) will be secondary if (i) your dependent has coverage through his/her own employer's plan or (ii) your dependent is eligible for Medicare benefits and the aforementioned conditions do not apply.

4. ***Exception for End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).*** If Medicare does not already have primary responsibility when you or your dependent becomes eligible for Medicare benefits because of End Stage Renal Disease: (i) the Plan will be primary for you or your dependent's claims for up to 30 months beginning with the month in which you or your dependent is first eligible for Medicare benefits because of ESRD; and (ii) the Plan will be secondary after the end of this 30 month period.

D. 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. Please also refer to the HIPAA privacy rules in this booklet for more information regarding protected health information.

E. Facility of Payment

Whenever payments which should have been made under this Plan have been made under another Plan the Administrator of this Plan shall have the right, in its sole discretion, to pay that amount to any organization (or another 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.

F. Right of Recovery of Excess Payments

If the amount of the payments made by this Plan is more than what 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.

G. Claims Resulting From Work-Related Injuries or Workers Compensation

The work-related claims provision in the applicable Kaiser Evidence of Coverage booklet will apply to claims covered by the Insurance Carrier or HMO. This provision applies to the self-funded benefits provided under the Plan. This Plan does not pay any claims for conditions arising out of or in the course of employment or other occupation for wages or profit, whether or not the individual is covered by Worker's Compensation Insurance.

If you file a claim that your Workers' Compensation carrier denies as a non-industrial condition(s), the Plan might cover otherwise eligible expenses, providing that you file an appeal of this denial with the Workers Compensation Appeals Board. You must furnish any information or assistance and execute any documents that the Board of Trustees or the Board's delegate may require or request to facilitate enforcement of their rights under this Section and take no action that may prejudice or interfere with the Plan's rights under this Section.

Participants and Dependents are required to pay to the Plan immediately any proceeds received by way of a court judgment, settlement or otherwise. Any Participant or Dependent who accepts payments from the Plan agrees that by doing so he is making a present assignment of his rights against such Workers' Compensation claim. These rules are automatic, but the Plan may require that any Participant sign an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require. Any Participant who refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the condition(s) involved. Any Participant who receives benefits and later fails to reimburse the Plan as set forth above will be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the Participant has failed to reimburse, including reasonable interest in such unpaid funds.

By accepting payments for the Plan, any Participant or Dependent agrees that the Plan may intervene in any legal action brought against the third party or any insurance company. A lien shall exist in favor of the Plan upon all sums of money recovered by the Participant or Dependent against the third party. The lien may be filed with the third party, the third party's agents, or the court. The Participant or Dependent shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent.
If the Participant settles or compromises a claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the Participant shall receive no further benefits from the Trust in connection with the medical condition(s) forming the basis of the Workers' Compensation claim, unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Trust.

ARTICLE XX: SUBROGATION, THIRD PARTY LIABILITY AND REIMBURSEMENT OBLIGATION

A. Definitions

The following definitions apply to this section of the Benefit Booklet:

1. **Covered Person** – means an individual covered by this Plan (such as the Participant or Dependent) 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, and other first-party or third-party contract or claim.

B. Subrogation Rights

This Plan does not provide benefits for any illness, injury, diseases or other condition for which a Third Party is or may be liable or legally responsible by reason of negligence, an act or omission, an intentional act or breach of any legal obligation on the part of that Third Party. Upon payment of Covered Charges for an Injury or Illness or disease or other condition of a Covered Person that are related to a Third Party Claim, the Plan 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 Plan or its Board of Trustees or its authorized representative may pursue the Third Party to recover the Covered Charges for an Injury or Illness or disease or other condition that are paid or may be paid by the Plan that are related to the Third Party Claim in the Plan 's name or in the name of a Covered Person. The Plan 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.

C. First Right of Recovery, Granting of Lien, & Creation of Constructive Trust

In addition to the Plan's subrogation rights, the Trust and its Board of Trustees require the Covered Person and his/her attorney, if any, to protect the Plan's reimbursement rights. The following rules apply as conditions for any Plan benefits that might be advanced:

1. A Covered Person agrees to hold any Recovery Funds in a Trust or escrow account for the Plan up to the amount of Covered Charges the Plan paid or may pay for the Injury or Illness of a Covered Person that are related to the Third Party Claim. The Plan shall be paid first from the Recovery

Funds. The Plan's reimbursement, restitution and subrogation rights shall extend to **any** property (including money) that is directly or indirectly in any way related to the Plan benefits involving the Third Party Claim. Reimbursement will be made by the Covered Person, the Covered Person's guardian, attorney or estate to the extent of, but not exceeding the total from any third-party as a result of a judgment, settlement, arbitration award or other arrangement (including receipt of proceeds under any uninsured and/or underinsured motorists coverage, no-fault coverage, or other insurance including the Covered person's own or family insurance coverage), regardless of how it is classified or characterized, to make whole the Plan for which such benefits have been paid when recovery is made.

2. A Covered Person grants the Plan an equitable lien and/or constructive Trust to all Recovery Funds up to the amount of Covered Charges the Plan 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 Plan until the Plan 's right to reimbursement in paragraph (c) has been fully satisfied. The lien may be filed with the third party, the third party's agents, or the court and the lien shall exist without regard to the identity of the property's source or holder at any particular time or whether at any particular time the property exists, is segregated, or whether the covered person has any rights to it.

3. The Plan 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 first priority rights and 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; (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; or (v) Covered Person recovers his full damages and/or attorneys' fees. The Board of Trustees reject the make whole, collateral source and common fund theories and the Plan '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 Plan 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. However, if an Agreement is not received and benefits are paid on behalf of a Covered Person relating to the Third Party Claim, the Plan's right to subrogation, reimbursements, restitution, and to a lien are automatic by accepting benefit payments from the Plan.

5. A Covered Person and his/her attorney shall do nothing to prejudice the Plan's right of recovery under this Subrogation and Reimbursement Obligations section of the Benefit Booklet. The Covered Person: (a) shall not assign any rights or causes of action he/she may have against others (including those under insurance policies) related to this section without the express written consent of the Plan; (b) take possession of any property subject to the Plan's lien in his/her own name, place it in a segregated account within his/her control (at least in the amount of the equitable lien), and not to alienate it or otherwise take any action so that it is not in his/her possession prior to the satisfaction of such lien; and (c) if such property is not in his/her possession (other than in possession by or on behalf of the Plan), to immediately take whatever steps possible to regain possession or have possession transferred to or on behalf of the Plan pursuant to its or its delegates direction; and (d) must cooperate with the Plan and take any action that may be necessary to protect its interests herein.

6. **IMPORTANT! Your Failure to Comply with the Plan's Rights.** The Plan may, at the discretion of its Board of Trustees, suspend payment or deny payment (or offset the amount which should have been reimbursed against any future benefit payments that may otherwise be payable under the

Plan to a Covered Person) 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.

7. If a Covered Person and/or his/her attorney settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the Covered Person shall receive no further benefits from the Plan in connection with the medical condition forming the basis of the Third Party liability claim unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Plan.

D. Additional Obligations of a Covered Person and Rights of the Trust and the Board of Trustees

In connection with the Plan 's right to subrogation and reimbursement, a Covered Person shall do the following as applicable and agrees that the Plan 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. This includes executing any documents that the Board of Trustees or its delegates may require or request to facilitate enforcement of their rights under this Section.

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 including keeping the Plan informed at all times of the status of any recovering and settlement negotiations and filing of litigation.

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 Plan and its Board of Trustees have the right to intervene in any lawsuit, mediation, settlement or arbitration filed by or on behalf of a Covered Person seeking damages from a Third Party or any insurance company, including the employee’s own carrier for uninsured motorist’s coverage or other insurance.

5. A Covered Person agrees that the Trust Administrative Office, Plan 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.

9. While the Plan's subrogation rights include the right to file an independent legal action or alternative dispute resolution proceeding against such Third Party (or to intervene in one brought by or on the Covered Person's behalf), it has no obligation to do so.

ARTICLE XXI: LEGAL RIGHTS, NOTICES AND DISCLOSURES

A. 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. Also, plans and insurers may not set levels of benefits or out-of-pocket costs so that any portion of the 48 hour (or 96 hour) as applicable stay is treated in a manner that is less favorable to the mother or newborn than any earlier portion of the stay. 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). You may be required to obtain preauthorization for any days of confinement that exceed 48 hours (or 96 hours).

B. 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 (including coverage for nipple and areola reconstruction, nipple and areola repigmentation to restore the physical appearance of the breast, as a required stage of reconstruction);
- 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. For more information, please call either Kaiser if you are enrolled under the Kaiser HMO plan or the Trust Fund Office if you are enrolled in the self-funded indemnity PPO plan.

C. Qualified Medical Child Support Orders/National Medical Support Notices

The Board of Trustees will recognize and be bound by Qualified Medical Child Support Orders and National Medical Support Notices. The Plan, through its Legal counsel, reviews all court orders potentially affecting health care benefits to determine whether they meet the requirements above for acceptance as a QMCSO. Legal Counsel, in consultation with the Fund Manager, makes a recommendation to the Board of Trustees whether an order meets the applicable requirements.

Federal law provides specific rules under which group health care plans are required to provide medical benefits to a child of a participant under a state domestic relations law or state law relating to medical child support. A court or state administrative agency may issue a Qualified Medical Child Support Order (QMCSO) that requires a group health care plan to provide medical benefits to a participant's child. The Plan will also recognize a properly completed National Medical Support Notice ("NMSN") that meets the requirements of the Employee Retirement Income Security Act ("ERISA").

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

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

For purposes of ERISA reporting and disclosure requirements, alternate recipients under any medical child support order, whether qualified or not, are treated as participants under the plan.

Requirements.

A medical child support order is qualified if it: (1) creates or recognizes an alternate recipient's right to receive benefits for which a participant or beneficiary is eligible to receive under a group health plan, or (2)assigns to an alternate recipient the right to receive such benefits; and (3) In addition, for an order to be a QMCSO/NMSN it must clearly specify the following information:

(i) Name and last known mailing address of the participant and of each alternate recipient covered by the Order,
(ii) Reasonable description of the type of coverage the plan is to provide to each alternate recipient or the manner in which the coverage is to be determined; and
(iii) Period to which the QMCSO applies.

Prohibited Provisions/Enrollment Requirements.

The order will fail to be a QMCSO/NMSN if it requires the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a state law relating to medical child support. The Plan requires that the Participant and all of his eligible Dependents be enrolled under only one Health Plan option. Therefore, a Participant must select and enroll in a Health Plan option that would be available to the Participant, the child(ren) covered under the QMCSO and./or NMSN and to the Participant's other eligible Dependents. If a Participant enrolls in a Plan that would not be available to the child(ren) covered under the QMCSO and/or NMSN because they reside outside of the Plan's service area, the Participant will be required to enroll in another Health Plan option that would cover the child(ren). The Plan will follow the requirements of the QMCSO and/or NMSN even if it requires that the Participant be forced to enroll in a different Plan option.

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

Procedures for Handling Court Orders & Determining QMCSO/NMSN.

The Trustees established reasonable procedures to determine whether a medical child support order is qualified and administer the provision of benefits under such qualified order. A group health plan must establish reasonable written procedures to determine whether a medical child support order is qualified and to administer the provision of benefits under a qualified order. These procedures, reproduced here, provide for the notification of each person specified in a medical child support order as eligible to receive benefits under the Plan promptly upon receipt by the Plan of the medical child support order, and permit an alternate recipient to designate a representative for receipt of copies of notices sent to the alternate recipient. The steps that the Plan office will follow to establish and determine whether a court order would qualify as a QMCSO/NMSN are:

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

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

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

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

Limited Purpose of Plan's Review of Order.

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

D. 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 or vision coverage through an insured plan, such as Kaiser or VSP, those vendors may have its own privacy practices to protect Your medical 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.

- **PHI Defined.** HIPAA only protects certain health information known as Protected Health Information ("PHI"). Generally, Protected Health Information is individually identifiable health and genetic 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 (or Business Associates including their subcontractors) 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.
- **De-Identified PHI.** This Notice does not apply to information that has been de-identified. De-identified information neither identifies nor provides a reasonable basis to identify you.
- **Minimum Necessary.** When using or disclosing PHI, the Plan will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological factors and limitations and any applicable law requiring greater disclosure.

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 PHI and not use or share your PHI other than as permitted under HIPAA and unless you tell the Plan it can in writing;**
2. **Provide You with certain rights with respect to Your PHI;**
3. **Give You notice of the Plan's legal duties and privacy policies regarding Your PHI;**
4. **Follow the terms of this section of the Benefit Booklet until modified;**
5. **Notify you promptly if a breach occurs that may have compromised the privacy or security of your PHI.**

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 PHI concerning HIV or AIDS, mental health, Substance Abuse, genetic testing, reproduction rights, and so on.

For more information please see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Our Uses and Disclosures

How do we typically use or share your medical information?

Under the law, the Plan may use and disclose Your Protected Health Information under certain circumstances without Your permission. The following chart describe different ways the Plan may use and disclose Your Protected Health Information. For each category of uses and disclosures, the Benefit Booklet will explain what is meant and may present examples. Not every use or disclosure in a category 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 categories.

Treatment.	The Plan can use your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you, including but not limited to consultations and referrals between your providers. *Example: Doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
For Payment.	We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. *Example: We share your eligibility for benefits information with Anthem Blue Cross to confirm whether payment will be made for a particular service.*
For Health Care Operations/Appeals.	The Plan can use and disclose health information about you for Plan operations that are necessary to run the Plan. The Plan may also release your PHI to the Board of Trustees or an Appeals Committee if it is needed to make a decision regarding an appeal. The Plan has a contractual arrangement with its Administrators relating to payment, health care operations or other matters pertaining to the plan. *Example: We use health information in reviewing & responding to appeals, medical reviews, legal services, audit services, Plan administrative activities, premium rating, or conducting quality assessment and improvement activities.*
As Required By Law.	The Plan can use and disclose your health information if required by state, federal or local laws. *Example: We share information with the Department of Health & Human Services for compliance with federal privacy laws.*
To Avert a Serious Threat to Health or Safety/Assist Public Health Issues.	The Plan can use and disclose your health information when it believes, in good faith, that such disclosure is necessary to prevent a serious threat to the safety and health of you, another individual, or the public. This includes disclosing medical information for public health activities to a public authority. These disclosures will be made for the purpose of controlling disease, injury or disability. *Example: We share health information to report suspected abuse, neglect or domestic violence if we have a reasonable belief, or to prevent disease, or to help with product recalls, or to prevent/reduce a serious threat to anyone's health or safety.*
To Inform You About Treatment Alternatives or Other Health Related Benefits.	The Plan may use PHI to identify whether you may benefit from communications from the Plan regarding (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination for you, or (4) recommended alternative treatments, therapies, health care providers, or settings of care for you. *Example: We may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.*
Disclosure to Health Plan Sponsor &	Medical information may be disclosed to the Plan Sponsors, i.e. IBEW Locals, and the Associations, or Plan Trustees, solely for purposes of administering

IBEW Local Unions.	benefits under the Plan.
Organ and Tissue Donation.	The Plan can share health information about you with organizations involved in procuring, banking or transplanting organs and tissues, as necessary.
Military, Veterans, and Inmates.	The Plan may release health information about you as required by military command authorities, if you are a member of the armed forces, or to a correctional institute or law enforcement official, if you are an inmate or under custody of a law enforcement official.
Respond to Lawsuits and Disputes.	The Plan can use and disclose your health information to respond to a court order, administrative proceeding, arbitration, subpoena, other lawful process or similar proceeding. *Example: We receive a discovery request in which you are a party involved in a lawsuit.*
Government or Law Enforcement Requests.	To the extent permitted or required by local/state/federal law, the Plan may release your health information to law enforcement official or for law enforcement purposes, to authorized government agencies, to health oversight agencies, or to comply with laws related to workers' compensation claims. *Example: We release health information because there is suspicion that your death was the result of a criminal conduct, or because of civil administrative or criminal investigations, audits, inspections, licensure or disciplinary action, or other activities necessary for the government to monitor government programs (such as Medicare fraud review), or for special government functions such as military, national security and presidential protective services.*
Research.	The Plan can use and share your health information for health research subject to certain conditions.
Child Immunization Proof to Schools.	The Plan may disclose proof of immunization of a student to the School, prior to admitting the student, where State or other law requires such information, upon obtaining the consent of the parent, guardian, or student of consenting age. Consent may be given by e-mail, in writing, over the phone, or in person.
Decedent's Health Information.	The Plan may disclose your PHI to your family members and others who were involved in your care or payment of your care, unless doing so is inconsistent with your prior written expressed wishes that was given to the Plan. However, PHI of persons who are deceased for more than 50 years is not protected under the HIPAA privacy and security rules. *Example: We disclose health information to a coroner or medical examiner necessary to identify a deceased person or determine the cause of death.*
Business Associates & Subcontractors.	The Plan may also share your PHI with business associates, including its employees, officers, directors, subcontractors or agents that perform certain administrative services for the Plan. As required by federal law, the Plan has a written contract with each of its business associates that contains provisions requiring them to protect the confidentiality of your PHI and to not use or disclose your PHI other than as permitted by the contract or as permitted by law.

Our Uses and Disclosures

For certain information, you can tell us your choices about what we what we Share.

Except as provided for in this Notice or as permitted by law, the Plan will not release your PHI without your written authorization. If you have a clear preference for how the Plan shares your information in the situations described below, contact the Plan office and tell the Plan what you want the Plan to do. The Plan Office has an Authorization Form that you may sign to authorize release of all or part of your PHI.

In these cases below, you have both the right and choice to tell the Plan to:

- ✓ Share information with your family, close friends, or others involved in your health care or payment for your case, as long as you do not object.
- ✓ Share information in a disaster relief situation.

If you are not able to tell the Plan your preference, for instance if you are unconscious or not around, the Plan may share your health information if the Plan believes it is in your best interest. The Plan may also share your health information when needed to lessen a serious and imminent threat to health or safety.

In these cases, the Plan will not share your information unless you give your written authorization subject to your right to revoke, amend, or limit your authorization in writing, at any time:

- ✓ **Psychotherapy Notes**. Psychotherapy notes are separately filed notes about your conversations with your mental health professional. Although this Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you.
- ✓ **Marketing Authorization**. The Plan cannot receive financial remuneration (direct or indirect payment) from third parties in exchange for the marketing of PHI unless permitted under HIPAA or with your prior written authorization. Marketing is any communication about a product or service that encourages recipients of the communication to purchase or use the product or service. This Plan never markets personal information.
- ✓ **Sale of PHI.** The Plan is prohibited from directly or indirectly receiving financial or non-financial remuneration in cash or in kind (including granting license rights) from a third party in exchange for your PHI unless permitted under HIPAA or with your prior written authorization. This Plan does not sell your PHI.
- ✓ **Fundraising Purposes**. Except as permitted under HIPAA or with your prior written authorization, the Plan cannot use or disclose your PHI for fundraising purposes. Although the Plan does not use nor does it intend to use your PHI for fundraising purposes, it must inform you of your right to opt out of receiving any fundraising communications (whether received in writing or over the phone) if it uses or discloses your PHI for fundraising purposes.
- ✓ **Genetic Information.** Your PHI includes genetic information. In regards to underwriting, which is premium rating, or similar activities, the Plan will not use or disclose genetic information about an individual, as prohibited under the Genetic Information Nondiscrimination Act of 2008. Also, the Plan cannot use your genetic information to decide whether it will give you coverage and the price of that coverage.
- ✓ **Other Uses of Medical Information.** Other uses and disclosures of health information not covered by this Notice or the laws that apply to the Plan will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of your responsibilities to help you. You have the following rights regarding Your Protected Health Information that the Plan maintains:

- ✓ **Right to Inspect and Copy Your Medical Information.** You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such medical information, you must submit your request in writing to the Plan Office. This includes the right to request a copy of your PHI in hard copy or electronic form contained in a designated record set for so long as the Plan maintains the PHI. The electronic form you request may be in the form of MS Word, Excel, text, or text-based PDF, among other formats. If the format you request is not readily producible, the Plan will provide you with a copy of your PHI in a readable format as agreed to by you and the Plan. Your requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy your medical information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Pursuant to government regulations, you do not have a right to copies of psychotherapy notes.

- ✓ **Right to Amend/Correct Your Medical Information.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend or correct the information. You have the right to request an amendment or correction for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan Office. In addition, you must provide a reason that supports your request. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your health information.

  We 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, we may deny your request if you ask us to amend information that (1) is not part of the medical information kept by or for the Plan, (2) was not created by us, unless the person or entity -that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy, or (4) or is accurate and complete.

- ✓ **Right to an Accounting of Disclosures.** You have a right to obtain an accounting of certain disclosures of your medical information. This right to an accounting extends to disclosures other than disclosures made to carry out treatment, payment or health care operations, to individuals about their own medical information, incident to an otherwise permitted use or disclosure, pursuant to an authorization, for purposes of creation of a facility directory or to persons involved in the patient's care or other notification purposes, as part of a limited data set, and for other national security or to correctional institutions or law enforcement officials.

  To request an accounting of disclosures, you must submit your request in writing to the Plan Office. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. Your request must specify a time period, which may not be longer than six years. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For

additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- ✓ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Plan Office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- ✓ **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Such requests shall be honored if, in the sole discretion of the Plan, the requests are reasonable and can be accommodated with minimal disruption to Plan administration. However, the Plan must say "yes" if you tell us you would be in danger if the Plan office does not honor your request. To request confidential communications, you must make your request in writing to the Plan Office. Your request must specify how or where you wish to be contacted.

- ✓ **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

- ✓ **Right to Provide an Authorization**. As noted above, the Plan may request your written authorization for uses and disclosures that are not identified by this Notice or permitted by law. Any authorization you provide regarding the use and disclosure of your PHI may be revoked at any time in writing.

- ✓ **Right to a File a Complaint**. If you believe your privacy rights have been violated, you may file a complaint with the Plan Office by contacting the Privacy Officer listed on following page or with the the U.S. Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling (877) 696-6775, or **visiting www.hhs.gov/ocr/privacy/hipaa/complaints**/. You must file a complaint within 180 days after the occurrence of the event or violation. You may also contact the Privacy Officer if you have any questions or concerns regarding your Privacy rights or regarding the specifics of filing a complaint. All complaints must be submitted in writing. You will not be penalized for filing a complaint and the Plan will not retaliate against you for filing a complaint.

- ✓ **Right to Notice in Event of Breach of Unauthorized Disclosure (Breach Notice)**. You have the right to receive and the Plan is required to provide a Notice to you, as soon as reasonably possible, but no later than 60 days after discovery of a breach of your unsecured PHI. There will be a presumption that any unauthorized acquisition, access, use, or disclosure of your PHI, in violation of the Privacy rule is a breach, *unless* the Plan demonstrates that there is a low probability that your PHI has been compromised based on the results of a risk assessment or an exception permitted by the Privacy Rule applies. This Plan has implemented a policy to require the performance of a risk assessment in all cases of impermissible uses or disclosures of PHI to ensure your PHI will not be compromised and intends on complying with any future guidance on risk assessments. The Board of Trustees will also report to the Plan any other security incident on an aggregate basis every year or more frequently based upon the Plan's written request.

- ✓ **Right to Restrict Disclosure of PHI If Paying Out-of-pocket.** If you paid for services out-of-pocket, in full, for a specific item or service, you have the right to ask your Health Care Provider to not disclose your PHI related to that item or service to the Plan for purposes of payment of health care operations. The Health Care Provider must accommodate your request, except where the Health Care Provider is required by law to make a disclosure.

- ✓ **Right to Choose Someone to Act For You (Personal Representative).** You may exercise your rights through a Personal Representative, who will be required to produce evidence of his/her authority to act on your behalf before he/she will be given access to your health information or be allowed to take any action for you. The Plan Office will verify that the person has this authority and can act for you before it takes any action. Proof of such authority may take one of the following forms: (a) notarized power of attorney for health care purposes or (b) court order of appointment of the individual as your conservator or guardian.

Changes to This Notice

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. The Notice is also available upon request (at any time) and on the Trust Fund website.

Requests for Information

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
6800 Santa Teresa Blvd., Suite 100
San Jose, CA 95119

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.

E. Patient Protection and Affordable Care Act

The information in this section is required by the federal Patient Protection and Affordable Care Act (the ACA).

Disclosure of Grandfathered Health Plan Statement (For Self-Funded Indemnity PPO Plan Only).

The Board of Trustees believes the self-funded Indemnity PPO Plan is a Grandfathered health plan under the ACA. 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 annual and lifetime limits on the Plan's Essential Health Benefits. For a definition of what constitutes an Essential Health Benefit, please visit www.healthcare.gov/glossary/essential-health-benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the 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.

Non-Grandfathered Health Plan (For Kaiser HMO Plan).

The Kaiser HMO/RX Plan is a Non-Grandfathered health plan under the ACA. As required by the ACA, a Non-Grandfathered health plan is required to provide preventive health services without any cost sharing, enhanced claims and appeals procedures, and certain other consumer protections, such as the elimination of annual and lifetime limits on the Plan's essential health benefits. If you are enrolled in the Kaiser HMO Plan, please contact the Trust Fund Office if you have questions about what it means to be a Non-Grandfathered Plan.

No Pre-Existing Condition Exclusions for Any Individual.

The ACA prohibits insurance plans in the individual and group markets from imposing pre-existing condition exclusions on any individual except for Grandfathered individual policies. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for an individual with cancer because the individual had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the individual because of the individual's pre-existing medical condition). This Plan including its insurers does not impose any pre-existing condition exclusions on any individual.

Dependent Child Coverage Through Age 25.

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

Minimum Essential Coverage.

The ACA established a minimum value standard of benefits for group health plans. The Board of Trustees believes this Plan (a jointly-sponsored multiemployer group health plan) provides minimum essential coverage and meets the minimum value standard for the benefits it provides. Minimum Value means the Plan's share of the total allowed cost of benefits provided is 60% or greater.

Availability of the Plan's Summary of Benefits & Coverage (SBC).

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

Elimination of Lifetime and Annual Dollar Limits on Essential Health Benefits.

The ACA prohibits both group health plans from imposing lifetime and annual dollar limits on Essential Health Benefits. In accordance with the requirements of the ACA, this Plan does not impose any lifetime and annual dollar limits on its Essential Health Benefits. However, the Plan (and Insurers) are permitted to impose annual limits on certain non-Essential Health Benefits consistent with the ACA and lawful

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

Prohibition on Rescissions of Coverage.

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

F. Individual Conversion of Health Coverage Rights

This section of the Benefit Booklet applies only if You reside in California and Your medical and prescription drug benefits are provided by the 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 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.

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

G. Mental Health Parity & Addiction Equity Act of 2008

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

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

H. General Provisions

1. **Incompetence or Incapacity.** In the event the Plan determines that the Covered Person is incompetent or incapable of executing a valid document or form and no guardian has been appointed, or in the event the Covered Person has not provided the Plan with an address at which he or she can

be located for payment, the Plan may, during the lifetime of the Covered Person, pay any amount otherwise payable to the Covered Person, the Covered Person's spouse, the Covered Person's blood relative, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the event of the death of the Covered Person before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Covered Person: lawful spouse, child or children, mother, father, brothers or sisters, or to the Covered Person's estate, as the Board of Trustees, in its sole discretion, may designate. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

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

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

3. **No Vested Rights to Benefit, Coverage, Payments Amounts or Any Other Aspect of the Plan.** Nothing in this Plan shall be construed as giving Employees, retired or terminated Employees, Dependents or any other person a vested right to continued coverage under this Plan. The Trustees retain full authority to amend or terminate coverage at any time and/or to increase premiums.

   a. **Incomplete Information/False Statements.** If you fail to provide requested information or give false information to verify disability, age, beneficiary information, marital status or other vital information, coverage under the Plan or benefits provided may be postponed or cancelled.

No benefits will be paid for fraudulent premiums, claims of services or supplied made by a Participant, Dependent, or any other person or for any other reasons (including, but not limited to enrolling an ineligible Dependent, failing to notify the Plan that a previously eligible Dependent no longer qualifies as a Dependent or failure to timely enroll in Medicare). If you make a false statement to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, you will be liable to the Plan for repayment of any benefits paid in reliance on such false statements or information, and any attorney's fees and costs incurred in effecting recovery or were otherwise incurred as a result of the false statement or information. This includes but is not limited to costs incurred by the Trust Fund Office, reasonable attorney's fees, costs, and interest charges. If any fraudulent claims have not been repaid when a participant or dependent incurs covered charges, the Plan may deduct any amounts owed including any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

I. TEMPORARY EMERGENCY EXTENSION RULES DURING PUBLIC HEALTH EMERGENCY PERIOD ONLY

Effective immediately, an emergency regulation jointly released by the Internal Revenue Service ("IRS") and Department of Labor ("DOL") requires the Plan to TEMPORARILY disregard the period from **March 1, 2020, until sixty (60) days after the announced end of the National Emergency or another date determined by the agencies in a future notice** (referred to as the "**Outbreak Period**") for all Plan Participants, Beneficiaries, or Claimants when determining the periods and dates referenced in this

section, but the **extended deadline will terminate the earlier of (1) One year from the date an individual is first eligible for the relief or (2) the end of the Outbreak Period, but in no event will an extended relief exceed One (1) year:**

1. **COBRA Qualifying Event Notice.** For Qualifying Events or receipts of the notice of COBRA continuation coverage occurring on or after March 1, 2020, the 60-day period to give a Qualifying Event Notice is temporarily extended and will terminate the earlier of: (1) one year from the date you (or your Dependents) were first eligible for an extended deadline or (2) the end of the Outbreak Period but, in no event will you (or your Dependent's) extended relief exceed One (1) year. **Please contact the Trust fund Office to determine your individualized situation.**

2. **COBRA Premium Payments (For Initial Payment and Ongoing Monthly Payments).** If COBRA coverage is first elected during the Outbreak Period, all monthly premium payments for all months for which coverage is elected are temporarily extended. This means if COBRA coverage is first elected during the Outbreak Period, your initial COBRA payment is temporarily extended and will be due the earlier of: (1) one year from the date an individual is first eligible for the extended relief (calculated from 45 days from the date of your COBRA Election) or (2) the end of the Outbreak Period (but in no event will your extended relief exceed One (1) year. For all ongoing monthly premium payments for which coverage is elected, coming due during the Outbreak Period are also temporarily extended and will be due the earlier of: (1) one year from the date an individual is first eligible for the extended relief (plus 30 days because the premium payment is considered timely pursuant to the COBRA statute if paid within 30 days of the due date) or (2) the end of the Outbreak Period (but in no event will your extended relief exceed One (1) year. **Please contact the Trust fund Office to determine your individualized situation.**

3. **COBRA Election Notice.** A Qualified Beneficiaries 60 day right to elect COBRA upon receipt of the COBRA Notice is temporarily extended and will terminate the earlier of: (1) one year from the date an individual is first eligible for the extended relief (calculated from the later of the date you are furnished the election notice or the date you lose coverage) or (2) the end of the Outbreak Period but, in no event will you (or your Dependent's) extended relief exceed One (1) year. **Please contact the Trust fund Office to determine your individualized situation.**

4. **Special Enrollment Rights.** For Participants that experience a birth, marriage or adoption as of March 1, 2020, their 30-day period to special enroll an eligible Dependent in the Plan upon birth, marriage, or adoption has been temporarily extended and will terminate the earlier of: (1) one year from the date the individual was first eligible for the extended relief or (2) the end of the Outbreak Period but, in no event will your extended relief exceed One (1) year. If you or your Dependent lose coverage under CHIPRA or Medicaid as of March 1, 2020, you or your Dependents 60-day period to special enroll in the Plan (subject to meeting the Plan's eligibility rules) upon a loss of CHIPRA or Medicaid coverage has been extended and will terminate the earlier of: (1) one year from the date the individual was first eligible for the extended relief or (2) the end of the Outbreak Period but, in no event will your Dependent's extended relief exceed One (1) year. **Please contact the Trust fund Office to determine your individualized situation.**

5. **Plan's Claims Filing Procedure.** Any benefit claims filing requirements (including the 1-year period to file suit from the date you receive a denial of an appeal or adverse action), for claims **as of March 1, 2020**, has been temporarily extended and will terminate the earlier of: (1) one year from the date the individual was first eligible for the extended relief or (2) the end of the Outbreak Period but, in no event will you (or your Dependent's) extended relief exceed One (1) year. If applicable, for those claims received/processed prior to March 1, 2020, any days that passed prior to the March 1, 2020, start date of the Outbreak Period will not be disregarded in determining a claims filing deadline but the days that fall within the Outbreak

Period will be temporarily tolled pursuant to federal guidance. **Please contact the Trust fund Office to determine your individualized situation.**

6. **Plan's Appeals Procedure.** For those claimants (or their authorized representatives) who received an adverse benefit determination/claims denial **as of March 1, 2020** the claimant (or authorized representative's) right to file an appeal within 180 days for health & welfare and disability-related claims has been temporarily tolled and will terminate the earlier of: (1) one year from the date the individual was first eligible for the extended relief or (2) the end of the Outbreak Period but, in no event will you (or your Dependent's) extended relief exceed One (1) year. If applicable, for those who received an adverse benefit determination or claims denial earlier than March 1, 2020, any days that passed prior to the March 1, 2020 start of the Outbreak Period will not be disregarded in determining your appeals filing deadline but the days that fall within the Outbreak Period will be temporarily tolled to federal guidance. **Please contact the Trust Fund Office to determine your individualized situation.**

J. CONSOLIDATED APPROPRIATIONS ACT of 2021 ("CAA")

Effective January 1, 2022, the Plan rules have been amended to comply with certain provisions of Division BB of the Consolidated Appropriations Act under the No Surprise Act (Title I) and Transparency (Title II) provisions, including any subsequent implementing regulations as it relates to the CAA. **For insured coverage (including HMO coverage), the Plan's respective insured carriers are responsible for compliance.**

1. **Identification Cards (CAA Section 107).** The Plan or Insurer's Identification Cards (currently with Kaiser and Anthem Blue Cross), whether physical or electronic, issued to a participant or its eligible dependents will include: (a) the amount of the in-network and out-of-network (if any) deductible and out-of-pocket maximums, (b) telephone number and website address to seek further consumer assistance.

2. **Ensuring Continuity of Care (CAA Section 113).** When a provider or contracted facility is removed from the Plan or Insurer's (as applicable) coverage, following termination of the provider/facility contract between the Plan/Insurer and the Provider/Facility, the Plan/Insurer (ex. Kaiser and Anthem Blue Cross) will timely notify participants or their eligible dependents who are receiving continuing care for a serious and complex condition (serious and complex condition means an acute illness that is a condition that is serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm or in the case of chronic illness a condition that is life-threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time) from that provider or facility that: (a) the Provider/Facility is no longer part of the Plan's network and (2) the Participant or eligible Dependent has the right to continue receiving transitional care for up to ninety (90) days at the in-network cost sharing and at the same terms that would have applied had termination not occurred.

3. **Accuracy of Provider Directory Information (CAA Section 116).**
   (a) ***Verification Process.*** Not less frequently than once every ninety (90) days the Plan or Insurer, as applicable (ex. Kaiser and Anthem Blue Cross) will verify and update its provider directory information included on the Plan or Insurer's database. Providers are required to submit regular updates to the plan to assist with the verification and update process, including notice of material changes to their provider

directory information. The database of provider directories must then be updated within two (2) business days of the plan receiving such data from the providers.

(b) ***Response Protocol.*** The Plan or Insurer, as applicable (ex. Kaiser and Anthem Blue Cross) will respond to a participant or dependent's request (whether by telephone, electronic, web-based or internet-based), within one (1) business day of the request, about a provider's network status. The Plan and Insurer must also retain communication records for two (2) years.

(c) ***Database.*** The Plan or Insurer, as applicable (ex. Kaiser and Anthem Blue Cross) will maintain a public website directory that contains a list of each of its contracted and facility providers, relevant information (name, address, specialty, number, digital contact information) and post information on balance billing protections and appropriate federal and state agency contacts to report violations.

(d) ***Cost-Sharing for Services provided Based on Reliance on Incorrect Provider Network Information.*** If participant or dependent provides documentation (ex. received through database, provider directory or response protocol) that he/she received and relied on incorrect information from the Plan or Insurer, as applicable (ex. Kaiser and Anthem Blue Cross) about a provider's network status prior to the visit and the item or services would otherwise be covered under the plan if furnished by a participating provider/facility, the Plan or Insurer, as applicable (ex. Kaiser and Anthem Blue Cross) cannot impose cost-sharing amount greater than in-network rates and it must count towards the participant or dependent's in-network out-of-pocket maximum and in-network deductible. If a provider submits a bill to an enrollee in excess of the in-network cost-sharing amount and the enrollee pays, the provider must refund that excess amount with interest.

4. <u>Surprise Billing Protections (CAA Sections 102 and 105).</u>

(a) ***Balance Billing Prohibition.*** Participants and dependents are prohibited from being balance billed for (1) **out-of-network emergency services**, (2) **non-emergency services performed by an out-of-network provider received at in-network facility**, and (3) **out-of-network air ambulance services**. Providers are prohibited from holding patients liable for excess amounts not covered by the Plan.

(b) ***Cost-Sharing Limits.*** In addition, for the three above-mentioned surprise items and services (#1, #2 and #3) any cost-sharing (such as copayment, coinsurance or deductible) must not be greater than the in-network cost sharing amount and must count towards the Plan's in-network deductible and out-of-pocket maximums, as of the items and services were provided by a participating provider. The participant or dependent's cost-sharing is based on the **Recognized Amount**. By statute, the recognized amount is (in order of priority) for only out-of-network emergency services and non-emergency services provided by an out-of-network provider at participating facilities:

(1) Amount determined by All-Payer Model Agreement, if applicable;

(2) Amount under specified state law (as applied to plans regulated by state law);
(3) The lesser of the billed charge or **Qualifying Payment Amount** (is the median of the contracted rates for similar services in a particular geographic area-based on the metropolitan statistical area adjusted by the consumer price index for inflation for items or services furnished during 2023 or subsequent years).

For out-of-network air ambulance bills the cost-sharing limit must be calculated by using the lesser of the: (1) billed charge or (2) qualifying payment amount.

(c) ***Determination of Out of Network Rates.*** By statute, the total amount to be paid to a provider/facility must be based on (less any cost-sharing from participant or dependent) the following out-of-network rate, in order of priority:
(1) Amount determined by All-Payer Model agreement, if applicable,
(2) Amount under specified state law (as applied to plans regulated by state law);
(3) Amount agreed upon by Plan/Insurer and Provider/Facility; and
(4) Amount determined by Independent Dispute Resolution Entity.

5. <u>Patient Protections Disclosure Requirements Against Balance Billing</u>

Plan or Insurer, as applicable (ex. Kaiser and Anthem Blue Cross) are required to make publicly available, by posting on the website of the Plan or Insurer and including on each Explanation of Benefits for an item or service as it relates to: (1) emergency services or (2) non-emergency services provided by non-participating provider at in-network facility, balance billing and patient protections in certain circumstances and appropriate government agency contact information if the participant or dependent believes the provider/facility has violated the No Surprise Act provisions.

6. <u>Out-of-Network Rate Independent Dispute Resolution Process for Certain No Surprise Act Items and Services (CAA Section 103).</u>

A federal Independent Dispute Resolution ("IDR") process (also known as an arbitration procedure) is required for disputes involving out-of-network rates between the Plan/Insurer and Out-of-Network provider/facility ("**disputing parties**") as it relates only to:
(1) out-of-network emergency services,
(2) non-emergency services provided by a non-network provider at an in-network facility,
(3) out-of-network air ambulance services; and
(4) Furnished to a covered participant or dependent who did not receive notice and/or did not provide adequate consent to waive the balance billing protections with regard to such items and services, pursuant to 45 CFR 149.410(b) or 149.420(c)-(i), as applicable.

The Departments have established the Federal IDR portal to administer the Federal IDR Process, available at <u>https://www.nsa-idr.cms.gov</u>.

Not all items and services are eligible for the federal IDR process. But, before initiating the IDR process, the disputing parties must first initiate a 30-day open negotiation period (meaning must engage in open negotiations within 30 calendar days of receiving initial payment or denial) to settle an out-of-network payment rate for covered items and services under the No Surprise Act. The 30 day calendar period begins on the date the plan receives the information necessary to decide a claim for payment for the services. If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the cost-sharing under the Plan, and the provider or facility is prohibited from billing the participant or dependent in excess of the required cost-sharing.

If an Out-of-Network provider or facility and the plan enter into the Independent Dispute Resolution (IDR) process under the federal No Surprises Act (Public Law 116-260, Division BB) and do not agree before the date on which a certified IDR entity makes a determination with respect to such item or service, the allowable amount is the amount of such determination.

Summary of Steps Preceding Federal IDR Process	
START	A furnished covered item or service results in a charge for emergency items or services from an OON provider or facility, for non-emergency items or services from an OON provider with respect to a patient visit to certain types of in-network facilities, or for air ambulance services from an OON provider of air ambulance services.
Within 30 calendar days	**Initial Payment or Notice of Denial of Payment** Must be sent by the plan, issuer, or carrier no later than 30 calendar days after a clean claim is received.
30 business days	**Initiation of Open Negotiation Period** An open negotiation period must be initiated within 30 business days beginning on the day the OON provider receives either an initial payment or a notice of denial of payment for the item or service from the plan, issuer, or carrier.
	Open Negotiation Period Parties must exhaust a 30-business-day open negotiation period before either party may initiate the Federal IDR Process.

NOTE: If any federal court case including, government guidance, regulations, and/or subsequent law invalidates any portion of the IDR process, as it relates to the No Surprise Act, then the invalidated portions will also not apply to this Plan.

In case of a failed open negotiation period, either party may initiate the federal IDR process as follows:

Timeline	Independent Dispute Resolution (Federal IDR Process)
4 business days	**Federal IDR Initiation** Either party can initiate the Federal IDR Process by submitting a Notice of IDR Initiation to the other party and to the Departments **within 4 business days** after the close of the open negotiation period. The notice must include the initiating party's preferred certified IDR entity. (**Note:** The Federal agencies have issued a standard notice with the required information that the initiating party must include to satisfy the IDR initiation notice requirement)
3-6 business days after initiation	**Selection of Certified IDR Entity** The non-initiating party can accept the initiating party's preferred certified IDR entity or object and propose another certified IDR entity. A lack of response from the non-initiating party **within 3 business days** will be deemed to be acceptance of the initiating party's preferred certified IDR entity. If the parties do not agree on a certified IDR entity, the Departments will randomly select a certified IDR entity on the parties' behalf. If random selection is necessary, the Departments will make the selection no later than **6 business days** after IDR initiation. The certified IDR entity may invoice the parties for administrative fees at the time of selection (administrative fees are due from both parties by the time of offer submission).
3 business days after contingent selection	**Certified IDR Entity Requirements** Once contingently selected, **within 3 business days,** the certified IDR entity must submit an attestation that it does not have a conflict of interest and determine whether the Federal IDR Process is applicable, thereby finalizing the selection.
10 business days after finalization of selection	**Submission of Offers and Payment of Certified IDR Entity Fee** Parties must submit their offers **not later than 10 business days** after finalization of selection of the certified IDR entity. Each party must pay the certified IDR entity fee (which the certified IDR entity will hold in a trust or an escrow account), and the administrative fee when submitting its offer (unless the administrative fee has already been paid). If the certified IDR entity fee and administrative fee are not collected from a party, the certified IDR entity will not accept the non-paying party's offer.
30 business days after	**Selection of Offer**

finalization of selection	A certified IDR entity has **30 business days** from the date of finalization of its selection to determine the payment amount and notify the parties and the Departments of its decision. The certified IDR entity must select one of the offers submitted.
30 calendar/ business days after determination	**Payments Between Parties of Determination Amount & Refund of Certified IDR Entity Fee** Any amount due from one party to the other party must be paid **not later than 30 calendar days** after the determination by the certified IDR entity. The certified IDR entity must refund the prevailing party's certified IDR entity fee **within 30 business days** after the determination.

Administrative Fee. Both parties are responsible for an administrative fee to participate in the Federal IDR process. If the certified IDR entity attests to having no conflicts of interest and concludes that the Federal IDR Process applies, the certified IDR entity must collect the administrative fee from both parties and remit the fee to the Departments. The administrative fee is based on an estimate of the cost to the Departments to carry out the Federal IDR process. The certified IDR entity retains the non-prevailing party's certified IDR entity fee as compensation unless the parties settle on an OON rate before a determination. If the parties settle or withdraw the dispute, the certified IDR entity will return half of each party's fee payment, unless directed otherwise by the parties.

Batched Items and Services. Batching means multiple qualified items or services that are considered jointly as part of one payment determination by a certified IDR entity for purposes of the federal IDR process. In order for a qualified IDR item or service to be included in a batched item or service, the qualified IDR item or service must meet the criteria set forth in 26 CFR 54.9816-8T(c)(3), 29 CFR 2590.716-8(c)(3), and 45 CFR 149.510(c)(3).

Certified IDR Entity. Certified IDR entity means an entity responsible for conducting determinations under 26 CFR 54.9816-8T(c) and 54.9816-8(c), 29 CFR 2590.716-8(c), and 45 CFR 149.510(c) that meets the certification criteria specified in 26 CFR 54.9816-8T(e), 29 CFR 2590.716-8(e), and 45 CFR 149.510(e) and that has been certified by the Departments.

Factors Considered by IDR Entity.
In determining which offer to select, the certified IDR entity must consider:
(1) The QPA(s) for the appliable year for the qualified IDR item or service; and
(2) Additional information relating to the offers submitted by the parties, which does not include information on prohibited factors (explained below).

When making a payment determination, the certified IDR entity must not consider the following factors:

- Usual and Customary charges including payment or reimbursement rates expressed as a proportion of usual and customary charges);
- Amount that would have been billed by the provider, facility, or provider of air ambulance services with respect to the qualified IDR item or service had the balance billing provisions of 45 CFR 149.410, 149.420, and 149.440 (as applicable) not applied; or

- Payment or reimbursement rate for items or services furnished by the provider, facility, or provider of air ambulance services payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act; the Medicaid program under title XIX of the Social Security Act; the Children's Health Insurance Program under title XXI of the Social Security Act; the TRICARE program under chapter 55 of title 10, United States Code; chapter 17 of title 38, United States Code, or demonstration projects under Section 1115 of the Social Security Act. This provision also prohibits consideration of payment or reimbursement rates expressed as a proportion of rates payable by public payors.

ARTCILE XXII: ERISA Statement

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

Plan Year. The Plan Year begins each January 1 and ends the following December 31

Plan Sponsor and Plan Administrator. This Plan is sponsored and administered by the:

Joint Labor-Management Board of Trustees of the
IBEW / NECA Sound and Communications Health and Welfare Plan
c/o United Administrative Services

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

Street Address
6800 Teresa Boulevard, Suite 100
San Jose, CA 95119

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 that provides life insurance, accidental death and dismember insurance, vision, dental, hospital and medical benefits to eligible employees and their dependents.

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

Street Address
6800 Teresa Boulevard, Suite 100
San Jose, CA 95119

Phone: (408) 288-4400/ Toll-Free: 1-800-541-8059

Agent for Legal Service.

Neyhart, Anderson, Flynn & Grosboll APC
Attn: Lois H. Chang & Richard K. Grosboll
369 Pine Street, Suite 800
San Francisco, CA 94104-3323

Service of legal process may also be made upon any member of the Board of Trustees.

Labor Trustees

Dan Romero
c/o I.B.E.W. Local Union No. 332
2125 Canoas Garden Ave., Ste 100
San Jose, CA 95125-1393

Herb Watts
c/o I.B.E.W. Local Union No. 180
720 Technology Way
Napa, CA 94548

Chuck Vella
c/o I.B.E.W. Local Union No. 617
1701 Leslie Street
San Mateo, CA 94402

Management Trustees

Doug Lung
c/o Santa Clara Valley Chapter NECA
P. O. Box 28899
San Jose, CA 95159

Rick Jensen
c/o JM Electric
400 Griffin Street
Salinas, CA 93901

Bill Kuhr
c/o San Mateo County NECA
950 John Daly Blvd., Suite 280
Daly City, CA 94015

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
6800 Teresa Boulevard, Suite 100
San Jose, CA 95119
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. 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, prescription drugs, 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
1-800-541-8059
www.anthem.com/ca

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
1-800-541-8059
www.anthem.com/ca

Health Maintenance Organizations / Alternate Health Plan. Employees and Dependents have the option of selecting medical and prescription drug coverage from a health maintenance organization (Kaiser Permanente). The medical and prescription drug benefits are insured and provided under contracts between the Trust and Kaiser Permanente Foundation Health Plan. 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
www.kaiserpermanete.org

Prescription Drug Program (Pharmacy Benefit Manager). The Plan's prescription drug program for Employees and Dependents is provided by MaxorPlus. The Trust is responsible for paying the prescription drug claims. A fee is paid to MaxorPlus for administering the prescription drug program.

MaxorPlus
1-800-687-0707
www.maxorplus.com

Mail Order Prescription Drug Program. The mail order prescription drug program for Employees and Dependents is provided by MXP Pharmacy. The Trust is responsible for paying the mail order prescription drug claims. A fee is paid to MXP Pharmacy for administering the program.

MXP Pharmacy

P.O. Box 32050
Amarillo, TX 79120-2050
1-800-687-8629
www.ppsrx.com

Mental Health Benefits. Mental Health benefits for Employees and Dependents enrolled in the Self-Funded Medical Indemnity PPO 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
www.optum.com
1-877-225-2267

Substance Abuse Benefits. Substance Abuse benefits for Employees and Dependents enrolled in the Self-Funded Medical Indemnity PPO 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
www.optum.com
1-877-225-2267

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
www.optum.com
1-877-225-2267

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
www.vsp.com

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:

Anthem Blue Cross Dental PPO
1-800-541-8059
www.anthem.com/ca

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 Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants 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, Internal Revenue Service and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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 (known as the Summary Annual report) at no cost.

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 under Your COBRA Continuation Coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 within one (1) year from the 30 day deadline you do not receive requested materials from the Plan. In such a case, the court may require the Plan administrator to provide the materials and pay You up to $112 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 within one (1) year from the time benefits are denied. 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 within one (1) year from the Plan's decision or lack of decision concerning the status of a medical child support order.

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/welcome.html .

ARTCILE XXIII: AMENDMENTS AND TERMINATION OF THE PLAN

A. Amendments

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

B. Mandatory Amendments

Amendment of the Trust or Plan shall be mandatory in the following situations:

1. When necessary to assure compliance with ERISA or other applicable laws;
2. When necessary to assure the tax-deductibility of contributions hereto under Federal and State Income Tax Laws;
3. When necessary to assure that this Trust remains tax exempt.

C. Termination

The Board of Trustees may terminate the Plan at any time subject to the Trust Agreement and applicable Collective Bargaining Agreements. Upon termination of the Trust, all obligations shall first be satisfied.

The Board of Trustees shall thereupon use the remaining Trust assets to provide Plan benefits in such manner as the Plan may provide, or in the absence of a Plan provision, to continue to provide Plan benefits in a manner permitted by ERISA for so long as Trust assets permit.

D. Transfer of Assets to Another Benefit Trust/Mergers and Consolidations

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

ARTCILE XXIIV: DEFINITIONS

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.

Ancillary Services- means with respect to a Preferred Provider facility:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
2. Items and services provided by assistant surgeons, hospitalists, and intensivists;
3. Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
4. Items and services provided by a Non-Preferred provider if there is no preferred provider who can furnish such item or service at such facility.

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 benefits provided under this Plan.

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. Effective 1/1/2022, for Emergency services, non-emergency services provided by a Non-Contract Provider at a Contract facility and Air Ambulance Services, the Allowable Charge or Allowable Expense or Covered Expense is the "Recognized Amount."

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. **Lawful Spouse.** An Employee's lawful 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. **Domestic Partner and Dependents.** An Employee's Domestic Partner and dependents who meet certain requirements. See definition of "Domestic Partner" below. 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. **Dependent Child.** 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 birth until the end of the month the child attains age 26.

4. **Disabled Dependent Child.** 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.

5. **Legal Guardianship Over Child.** A child who resides with an Employee for whom the Employee is the child's legal guardian pursuant to the same provisions for coverage of children of the Employee, provided documentation of the court order granting the Employee guardianship over the child is provided to the Trust Fund office. The same age status requirement that apply to a natural child, stepchild, and legally adopted child also apply to a child for whom an Employee is the legal guardian.

6. 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 - Is defined as a same-sex and opposite-sex couple registered with any state or local government agency authorized to perform such registration pursuant to that state or local law. Generally, a Domestic Partner registered in the State of California (as defined under the California Family Code section 297) and/or registered in the City and County of San Francisco, requires the following:

1. Both person have an intimate, committed relationship of mutual caring, and live together.
2. Are responsible for each other's basic living expenses during the domestic partnership.
3. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
4. The two persons are not related by blood in a way that would prevent them from being married to each other in California.
5. Both persons are at least 18 years of age.
6. Both persons are capable of consenting to the domestic partnership.
7. Both persons are not related by blood kinship in a way that would prevent them from being married to each other.
8. Both persons are members of the same sex, OR one or both of the persons is over 62 years of age and one or both meet the eligibility criteria under Title II of the Social Security Act as defined in United States Code, title 42, section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in United States Code, title 42, section 1381 for aged individuals.

Health and welfare coverage can start the first of the month after (i) proof of the registered Domestic Partnership has been provided to the Trust Administrative Office; (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.

Coverage for the Domestic Partner and the Domestic Partner's Children who qualify as Dependents will terminate on whichever of the following dates is applicable:

(3) On the first day of the month following the date on which he/she no longer qualifies as a Dependent; for example, one of the partner dies, one of the partners marries or the partners no longer live together, or Dissolution of Domestic Partnership occurs.
(4) Date the Participant Employee's health and welfare coverage ends.

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:
a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual or with respect to a pregnant woman the health of the women or her unborn child in serious jeopardy; clause (ii) which refers to serious impairment to bodily functions and clause (iii) refers to serious dysfunction of any bodily organ or part. Effective January 1, 2022, the emergency department of a hospital also includes an independent freestanding emergency department.

Emergency Services- means medical screening examination that is within the capability of the emergency department of a hospital or an independent freestanding emergency department, ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and pre-stabilization services and treatment to stabilize an individual (regardless of the department of the hospital in which such examination or treatment is furnished). Emergency Services furnished by a Non-preferred provider or Non-preferred emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

(i) The provider or facility determines that the participant or dependent is able to travel using nonmedical transportation or nonemergency medical transportation; or

(ii) The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Contract provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Contract providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract providers listed; and

(iii) The participant or dependent gives informed consent to continued treatment by the Non-Contract provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Contract provider may result in greater cost to the participant or dependent.

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.

Independent Free Standing Emergency Department- means a health care facility that is geographically separate from a hospital under applicable state law and provides emergency services

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.

Qualifying Payment Amount- means the amount calculated using the method described in the No Surprise Act regulations under 29 CFR 716-6(c).

Recognized Amount- means (in order of priority) one of the following:

(i) If applicable, the amount determined by All-Payer Model Agreement under Section 1115A of the Social Security Act;
(ii) If applicable, the amount specified by State law (as applied to plan regulated by state law);
(iii) The lesser of the billed amount charged by the provider or facility or the Qualifying Payment Amount.

For air ambulance services furnished by Non-Contract providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

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.

Serious and Complex condition means with respect to a participant or dependent, one of the following:

(i) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent disability;

(ii) in the case of a chronic illness or condition, a condition that is a life threatening, degenerative, potentially disabling or congenital; and requires specialized medical care over a prolonged period of time.

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 – The applicable Third Party Administrator that has contracted with the IBEW/NECA Sound and Communications Health and Welfare Trust Fund to administer and manage the benefits and claims of the Plan. The current Administrator is United Administrative Services, whose address is 6800 Santa Teresa Blvd., San Jose, California 95119.

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. Effective 1/1/2022, for Emergency services, non-emergency services provided by a Non-Contract Provider at a Contract facility and Air Ambulance Services, the UCR is the “Recognized Amount.”

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.

IBEW/NECA
SOUND & COMMUNICATIONS HEALTH AND WELFARE PLAN

Adoption Resolution

RESOLVED, that effective January 1, 2023, the Board of Trustees of the IBEW/NECA Sound and Communications Health and Welfare Plan ("PLAN") hereby adopts this Restated Summary Plan Description and Plan Document.

The benefits provided by the Plan can be paid only to the extent that the plan has available resources for such payments. No contributing employer has any liability, directly or indirectly to provide the benefits established hereunder, beyond the obligation of the contributing employer to make contributions required in the applicable collective bargaining agreement(s). Likewise, there shall be no liability imposed upon the Board of Trustees, individually or collectively, or upon the Union, Signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Plan does not have sufficient assets to make benefits payments.

APPROVED:

_____	_____
Dan Romero, Chair	**Doug Lung, Co-Chair**
Date:_____	**Date:** _____