

NECA WEST HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION



National Electrical Contractors Association

**August 1, 2009
DRAFT**

TABLE OF CONTENTS

IMPORTANT NOTICES:	5
I. ELIGIBILITY REQUIREMENTS	6
II. CHANGES IN COVERAGE.....	11
III. GENERAL LIMITATIONS	12
IV. STANDARD PROVISIONS.....	12
V. CONTINUATION OF COVERAGE	12
VI. RETIREE MEDICAL COVERAGE.....	15
VII. MEDICAL BENEFITS	17
VIII. DENTAL BENEFITS	18
IX. VISION CARE BENEFITS	18
X. LIFE INSURANCE BENEFIT.....	18
XI. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS.....	18
XII. NOTICE TO THOSE ELIGIBLE FOR MEDICARE PART D.....	19
XIII. COBRA	20
XIV. FAMILY AND MEDICAL LEAVE ACT	23
XV. RIGHTS OF STATES	24
XVI. FEDERAL NOTICES.....	24
XVIII. GENERAL PROVISIONS	31
XVIII. POTENTIAL LOSS OF BENEFITS	35
XIX. GENERAL INFORMATION	36
XX. HIPAA.....	40

ALERT

The Benefits provided under this Plan may be changed at any time. The Board of Trustees may reduce or eliminate any benefits and may change or eliminate insurance carriers, HMOs, PPOs, or any other entity to make additional contributions for coverage at any time.

The benefits in this Summary Plan Description are as of the date prepared. Any subsequent amendments will govern the actual benefits payable.

August 1, 2009

Dear Participant:

This booklet known as a Summary Plan Description contains general information regarding your Insurance Benefits and an explanation of the eligibility provisions. We urge you to familiarize yourself with the provisions and benefit structure of your Plan.

Please remember that this booklet is only a summary. In the event of any dispute, the official language of the group insurance policy, or other master agreements, will be in control.

For details on your benefit coverage, please refer to the Providers' Evidence of Coverage. These documents are the binding documents between the Insurance Plan and its participants. You should review the booklets and other documents furnished by the entities providing benefits for the Plan.

The provider has discretion to make any factual determination concerning your plan.

Only the full Board of Trustees is authorized to interpret the Plan. The Board 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 or Employer has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board. The Board also has discretion to make any factual determinations concerning your claim.

Open Enrollment is held each year, from November 5th through December 5th; you may elect to change your benefit plan options selection by completing a new enrollment card through the Administration Office. Your change must be received by the Administration Office by December 5th and will be effective January 1st that year. Provider benefit booklets are available at the Administration Office.

The Board of Trustees has authorized the Administration Office to respond in writing to your written questions. If you have an important question about your benefits, you should contact the Administration Office as follows:

United Administrative Services
1120 S. Bascom Avenue
San Jose, CA 95128
(408) 288-4400

Plan rules and benefits may change from time to 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.

The purchase of the benefits described in this booklet is made possible by your Employers contribution to the Fund on your behalf. Be sure to check with your employer to verify coverage.

The Board of Trustees

IMPORTANT NOTICES:

FUTURE PLAN AMENDMENTS

Future amendments to the Plan may be made from time to time to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Trustees.

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 Administration Office, a Trustee, an Employer, or any other person or entity.

As a courtesy to you, the Administration 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 Administration Office. **To make their decision, the Trustees must be provided with full and accurate information concerning your situation. You should also ensure that you provide accurate facts in all forms and documents submitted to ensure you are not held liable for coverage of ineligible Dependents and/or claims.**

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

NO VESTED RIGHTS

Benefits under this Plan are NOT vested. The Board of Trustees may 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, at any time. Moreover, the Board of Trustees may require new or greater co-payments at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.

USE OF MASCULINE GENDER WORDS

In all situations, whenever any words are used in the Plan in the masculine gender, they should be construed as though they were also used in the feminine gender where they would so apply.

I. ELIGIBILITY REQUIREMENTS

A. General

Your employer will provide you with information regarding coverage options at the time you become eligible for coverage. Options and eligibility dates may vary depending upon your employer. Some employers offer only one option while others may offer multiple options. This applies to the number of HMO options and whether dental or vision coverage is available.)

B. Eligible Employer

1. Contractors who are members in good standing of the National Electrical Contractors Association (NECA), whose principal business is within the geographical area of District Nine of NECA (California/Nevada) and who sign a participation/subscription agreement;
2. NECA Chapters in the geographical jurisdiction of District Nine that sign a participation/subscription agreement; and
3. Other industry related organizations sponsored by NECA chapter and approved by the Board of Trustees that sign a participation/subscription agreement.

C. Eligible Employee

Permanent full-time employees of an Eligible Employer are eligible employees. A full-time Eligible Employee must perform work 30 or more hours per week for the Eligible Employer and not be a member of a collective bargaining unit. All such employees must be enrolled in the Plan.

An employee who is a covered dependent under a spouse's health care plan may be excluded from the classification of "permanent full-time employee" if he signs a waiver of coverage acknowledging that he can only become covered under a plan sponsored by the Trust at open enrollment. The Plan will provide the "waiver of coverage" form.

D. Initial Eligibility

Initial eligibility is established by your employer. Coverage may be immediate or there may be a waiting period for as long as ninety (90) days from your date of hire. Check with your employer to determine the eligibility date.

E. Premium Payments

Your employer must submit premium payments on a monthly basis for continued eligibility. Premium payments are due by the 15th of the month prior to the month of coverage. As an example, payment on January 15th provides coverage for the month of February.

F. Covered Dependents

Your Covered Dependents are your lawful spouse (husband or wife) if not legally separated from the employee, natural children, legally adopted children and stepchildren.

A dependent's coverage will become effective on the later of

- 1) the date you become eligible or your dependent becomes eligible for Dependent Coverage or
- 2) the date your dependent becomes an eligible dependent, (due to marriage, birth adoption), provided the required dependent contribution is timely received.

After Dependent Coverage is in effect, you must make application to add any new dependent.

Proof of good health will not be required for your dependents if you

- Were a participant in an HMO plan; and
- Apply for medical benefits under the Plan;

- During an open enrollment period;
- When a change in the location of your employment or residence causes you to leave the HMO plan;
- When the HMO plan ceases to operate; or
- Prior to or within five days of your disenrollment in the HMO plan.

A pre-existing condition waiting period will not be applied to pregnancy for newborns or a child under 18 who is adopted or placed for adoption, if covered within 30 days of birth, adoption or placement. At any other time proof of good health may be required.

The rules for a Dependent child shall be:

1. Blood Descendent: A blood descendent of the first degree;
2. Adopted Child: A legally adopted child, including children living with adopting parents during the period of probation and children for whom the adopting parents have assumed and retained a legal obligation to provide total or partial support in anticipation of adoption;
3. Stepchild: A stepchild residing in the employee's household; and
4. Related Child or Children: A child residing permanently with the employee, who is head of the household, and who is being solely supported by the employee. Except for children who have been or are being adopted by the employee, the child must be related by blood or marriage to the employee, or the employee must be the child's legal guardian;
5. Adding Dependents: During the period you continue to have coverage, any new eligible dependents you acquire may be added in accordance with the dependent's eligibility provisions, and any eligible dependents you decline to insure before your continued health coverage began may be added during any open enrollment period provided by the plan. Coverage will be immediate for all dependents without any preexisting condition limitations;
6. Age Limit for Children/Students: Covered Dependents are eligible for all benefits provided from birth through the age of 18 years, provided such children are unmarried, and dependent upon their parents for support and maintenance, and

reside with you in a parent-child relationship. Children also include those from age 19 years and underage 24 years provided they are attending an accredited and state licensed technical school or institution of higher education on a full-time basis, are unmarried and are dependent upon you for support and maintenance.

7. Student Breaks (Summer Months and Periods of Vacation):

a) Summer Months: During the Summer months (i.e. quarter/semester), coverage will be extended provided the Dependent child continues to meet all Plan eligibility requirements, was a Full-Time student the semester/quarter immediately preceding the Summer break and has enrolled or intends to enroll as a Full-Time student the quarter/semester immediately following the Summer months.

b) Periods of Vacation: A Period of Vacation from Full-Time enrollment does not necessarily terminate a Dependent child's coverage and a Dependent child might qualify for coverage during a period of vacation from full-time enrollment. A period of vacation is defined as one quarter/semester in which a Dependent child is enrolled in less than 9 units of study. In order to qualify for coverage during a Period of Vacation from Full-time enrollment a Dependent child must meet ALL of the following:

a. The Dependent child must meet all other Dependent eligibility requirements and the Participant would be required to sign a statement under penalty of perjury to this effect; and

b. The Dependent child must have been enrolled on a Full-Time basis the semester/quarter immediately preceding this period of vacation (excluding Summer break); and

1) The Dependent child must intend on again enrolling on a Full-Time basis the quarter/semester immediately preceding this period of vacation (excluding summer months). Please be aware that if a Dependent child fails to meet all other plan qualifications for Dependent children during a period of vacation, was not enrolled on a Full-Time basis the semester/quarter immediately preceding the period of vacation, or does not intend on enrolling on a Full-Time basis immediately after this period of vacation, the Dependent child would not qualify for coverage during this break from Full-Time enrollment; and

8. Disabled Children: A dependent child also includes a child after his 19th birthday provided the child is both incapable of self-sustaining employment by reasons of mental or physical disability; and chiefly dependent upon you for support and maintenance. Such qualifications will continue coverage for the child beyond his 19th birthday and underage 24.

The Administration Office must receive proof of such incapacity and dependency within 31 days of the child's 19th birthday. **THAT IS YOUR RESPONSIBILITY.** The Trust may require, at reasonable intervals following the child's 19th birthday, proof of the child's continued disability and dependency.

No dependent can ever be deemed a Covered Dependent unless he or she is a dependent of a Participant.

**IMPORTANT NOTICE:
WARNING ABOUT FRAUD AGAINST PLAN**

It is the Participant's and Dependent's responsibility to notify the Administration Office immediately when a Dependent's status changes. This includes divorce/final dissolution of marriage, legal separation, death, a Dependent child over 19 who is no longer enrolled as a full-time student, a child over 19 being employed with health coverage, and any other events which would make your Dependent not eligible for future coverage. If claims are paid for, or premiums are paid on behalf of any Dependent and it is later found that the Dependent was not eligible, you and the Dependent each will be responsible for reimbursing the Plan for the actual amount paid out in benefits (and/or premium payments) by the Trust plus interest and any costs and attorney's fees incurred to recover the money.

G. Domestic Partners

A Covered Participant's domestic partner will be covered provided the domestic partnership meets the following criteria:

1. Both persons must file a Declaration of the Domestic Partnership with the Secretary of the State of California and provide a copy to the Administration Office;^{*1}
2. Both persons must have a common residence;
3. Neither person may be married to someone else or be a member of another domestic partnership with someone else that has not been terminated;
4. The two persons must not be related by blood in any way that would prevent them from being married to each other;
5. Both persons are at least 18 years old; and
6. Both persons must be capable of consenting to the domestic partnership.

In addition to the above requirements, both the Covered Participant and the domestic partner agree to immediately inform the Administration Office of the termination of their domestic partnership as a result of a change in one or more of the above requirements or the death of the domestic partner.

The election by a Participant to add a domestic partner may have certain Federal income tax implications. Under Federal tax law, the fair market value of health coverage provided to a domestic partner is a taxable benefit to the Participant. (Please note that domestic partner benefits are not taxable under California law.) Each year the Plan will calculate the fair market value of the domestic partner coverage and this information will be sent to participating employers. The Participant's employer is then responsible for including the

¹ For those Participants who do not live in the State of California and are, therefore, not eligible to file a Declaration of Domestic Partnership with the Secretary of State's Office, the Fund will accept a properly completed Affidavit of Domestic Partnership as proof of the domestic partnership so long as the criteria set forth in 2-7 above is met. The Fund Administration Office will provide Participants with the Affidavit upon request.

imputed income on the Participant's wages and withholding any FICA, FUTA, Medicare and Federal income taxes as applicable.

H. Automatic Coverage for a Newborn Child- If Plan Notified Within 31 Days

A newborn or newly adopted child of any age will automatically be covered for the first 31 days of medical benefits on the date the child becomes a Dependent; however, you are required to apply for Dependent coverage for that child within 31 days of the child's birth or of the adopted child's placement in your home in order to continue that child's coverage beyond the first 31 days. You are urged, however, to enroll the new child immediately. **If you fail to do so, there is no coverage.**

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

I. Qualified Medical Child Support Orders (QMCSO)

The Participant must timely provide the Administration Office with a copy of any court order that establishes the Participant's legal obligation to maintain coverage on a Dependent Child including a Qualified Medical Child Support Order (QMCSO).

A QMCSO recognizes an eligible child's right to receive Plan benefits as a dependent of an eligible Plan Participant. The child, to be covered for benefits by this Plan, must meet Plan requirements for an eligible Dependent child including age requirements.

The steps that will be followed to establish and determine whether a court order would qualify as a QMCSO are:

1. The Participant must provide the Administration Office with a copy of the court order and/or QMCSO.
2. Within thirty (30) days after receipt of the QMCSO or within a reasonable period, the Plan Office or the Plan's legal counsel will notify the Participant in writing if the court order and/or QMCSO is acceptable to the Plan.
3. If the Plan determines that the court order and/or QMCSO 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 is denied.** The notice will describe the reasons for denial. There is a right to appeal a denial. A description 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.
 - 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.

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 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 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 even if that requires that the Participant be forced to enroll in a different Plan option.

Please be aware that if a child covered under a QMCSO 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 has been enrolled in.

II. CHANGES IN COVERAGE

When your benefits or benefit amounts change because of a change in coverage or class, the new benefits or amounts will become effective on the date of the change in coverage or the first day of the month which falls on or next following the change in class.

When a change increases the Life and AD&D benefits, it will take effect only if you are actively at work on that date. Otherwise, such increase will take effect on the date you return to active work. When a change is a decrease in such benefits, it will take effect on the date of the change.

A change in medical benefits will take effect on the change date.

A change in your dependent's coverage because of a change in your benefits, benefit amounts or class will become effective on the date your benefits change. The change will take effect only if your Eligible Dependent is not hospital confined on that date. Otherwise, the change will take effect the day after discharge from the hospital.

A change in the Dental Benefit will apply only to a plan of dental treatment which starts after the date of such change.

III. GENERAL LIMITATIONS

The following limitations apply to all benefits except Life and AD&D. Those benefits will include their own limitations, if any. Additional limitations which apply to a specific benefit will be included with the description of that benefit herein.

The benefits in this booklet do not cover

Any injury or sickness

- a. From, or in the course of, any work for pay or profit;
- b. For which you have the right to benefits under any Workers' Compensation Law, or similar law.
- c. Caused by an act of war, declared or not;
- d. Self-inflicted and/or intentional injury, or an illness (unless caused by a medical condition as defined by HIPAA). This exclusion shall include an illness or injuries which were incurred as a result of the Plan Member's use of alcohol or drugs, in excess of a state or federal statute, or non-prescribed use as defined by a licensed medical examiner.

Charges for care, treatment, services or supplies:

- a. Paid for by a federal, state or local government agency, or
- b. Provided by a hospital run by such agency; unless, by law, you or we must pay the charges.

IV. STANDARD PROVISIONS

A. Legal Actions

No action at law or equity shall be brought to recover on the plan until 60 days after written proof of loss is required to be given. No such action will be brought beyond two years after written proof of loss is required to be given.

B. Change of Beneficiary

You may change your beneficiary at any time provided the change is in writing and submit to the Administration Office. When recorded, the change will take effect as of the date the beneficiary form was signed, provided the Administration Office receives it before benefits have been paid. Any payment so made in good faith will fully discharge the Plan to the extent of the payment. The beneficiary records may be kept by Blue Shield, the Plan or by a Plan Administrator. In the event no beneficiary form has been executed any death benefits payable by the Trust will be paid according to the California laws of intestate succession.

V. CONTINUATION OF COVERAGE

A. Premium Payments

Your employer must submit premium payments on a monthly basis for continued eligibility. Premium payments are due and must be received by the 15th of the month prior to the month of coverage. As an example, payment on January 15th provides coverage for the month of February.

B. Pre-Existing Conditions

Pre-existing conditions may be excluded from coverage subject to the Health Insurance Portability and Accountability Act (HIPAA) limitations.

A pre-existing condition is defined as an illness, condition or set of symptoms that originated, were diagnosed, were being treated, or had medication prescribed the immediate six months prior to enrollment under this Plan. Also included are complications and any results of treatment of any pre-existing condition.

A condition is diagnosed whenever a health care provider tell a person that he or she either has may have had that condition or makes an entry to that affect in the person's medical records. This applies even if the physician is examining or treating a person for a different condition.

In addition to the above criteria for pre-existing conditions, chemical dependency and/or mental health conditions will be considered pre-existing conditions if there was court directed care, professional treatment or recommended care, or voluntary program attendance within the immediate six months prior to the coverage effective day of this plan. Your HMO booklet will explain any pre-existing limitations.

C. Newly Acquired Dependents – 30 Days to Enroll

It is important for a participant to complete a change of enrollment form if he or she wishes to add a new spouse or newly acquired dependent children. This must be done within 30 days of individual(s) becoming the participant's dependent(s).

It is important for a participant to complete a change of enrollment form, within 30 days of birth, or in case of adoption, the date the child is placed in the participant's custody. You, as a participant, must obtain and complete a new enrollment card from the Administration Office to add additional dependents.

D. Military Service

Any eligible person who enters the military service or military training under the laws of the United States may elect to have coverage suspended. This request must be made in writing to the Board of Trustees and will be effective the first day of the month following receipt of the request. See address below.

You should notify the Administration Office in writing, as soon as you are aware that you will resume active work by sending a letter to:

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

E. Uniformed Services Employment And Reemployment Rights Act (USERRA)

In accordance with the Uniformed Services Employment and Reemployment Rights Act, if you are on military leave you will retain continuation coverage rights similar to those described under COBRA. Continuation coverage will be limited to a term that ends on the earlier of 18 months or the date on which USERRA requires you to offer to return to civilian employment. That date is determined by the following rules:

- a. If the period of military service is less than 31 days you must return, and 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.
- b. If the period of service is 33 to 180 days, you must return and 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.
- c. If the period of service is 181 days or more, you must return and continuation coverage will end no later than 90 days after completion of your military service.
- d. If you suffer from a service-connected injury or illness, the deadlines for returning to work are extended for up to two years while you are hospitalized or convalescing.

If you are on military leave for less than 31 days, there will be no charge to you for your medical coverage. Otherwise, you and your eligible dependents must file a timely application following the end of the initial 30 day period of military service, make monthly self-payments directly to the Administration Office, and notify the Administration Office and your employer that you are leaving work for military service.

Continuation coverage under USERRA will not terminate if you or your dependents become covered by another group health plan.

F. HMO Enrollees

If you or your spouse or dependent have USERRA continuation coverage through the Plan's HMO programs and you are terminated from the program because you move out of the HMO's service area before the applicable USERRA period expires and the Plan does not have a contract with your HMO in that area, you or your spouse or dependent will be allowed to enroll in the Group Medical Plan until the expiration of the applicable USERRA period, so long as payment of USERRA premiums are continuous and timely and the other USERRA requirements are met for the continuation of health coverage. Please call the Administration Office for additional details.

VI. RETIREE MEDICAL COVERAGE

A. Early Retiree

If you are a retiree, between the ages of 55 and 64 you may want to continue to participate in the Plan's of benefits as an early retiree by making self-payments pursuant to a written agreement provided by the Trust which you will have to sign. To be eligible for the Early Retiree Hospital-Medical Coverage, you must:

- be between the ages of 55 and 64;
- have had medical coverage under this Fund for the last twenty-four months immediately prior to the last month on which a contribution was made on your behalf by a participating employer; and
- have been employed with a participating employer for at least 10 years.

Any dependents that were listed with the Administration Office at the time of your retirement may also be continued on your coverage. Eligible dependents who survive you may continue to self-pay for the same coverage, as long as they remain dependents.

B. Normal Retiree

If you are a retiree over the age of 65 and are receiving Medicare Parts A and B coverage you may be eligible for one of the Medicare Supplement or Medicare Risk programs offered by the Plan by making self-payments pursuant to a written agreement provided by the Plan which you will have to sign. To be eligible for the Normal Retiree Medicare Supplement or Medicare Risk programs, you must:

- be age 65 or older;
- have had medical coverage under this Plan for the last two years immediately prior to the last month on which a contribution was made on your behalf by a participating employer; and
- have been employed with a participating employer for the last 10 years.

For an additional premium, dependents who were listed with the Administration office at the time of your retirement may be continued on your coverage.

Continuous Plan Coverage is required for eligibility and failure to make timely premium payments will result in loss of coverage. Except as provided below under special enrollment periods, payment for your Retiree coverage must begin the month following your termination from the active employee program so that your coverage is continuous. If you selected "COBRA Continuation Coverage", your retiree coverage must begin at whatever time your Continuation Coverage is terminated. Failure to make the required payments within 15 days of the due date will permanently terminate your coverage.

A retiree who is eligible but not enrolled under the Retiree medical plan will have a special enrollment period if each of the following conditions is met:

1. The retiree was covered under a group health plan or had health insurance coverage at the time coverage was previously offered.
2. The retiree stated in writing that the reason for originally declining enrollment was that he had coverage under another group benefit plan or health insurance coverage.
3. The retiree's coverage described in paragraph 1 either was under COBRA which was exhausted, or the coverage was not under COBRA and terminated as a result of loss of eligibility, or employer contributions toward such coverage were terminated.
4. The retiree requests enrollment under this Plan not later than 30 days after the exhaustion of COBRA coverage or other termination of coverage described in paragraph 3.

A person who becomes a dependent of a retiree through marriage, birth or adoption, shall be entitled to be enrolled in the Plan within 30 days after such marriage, birth or adoption.

C. Medicare Coordination--YOU ARE REQUIRED TO ENROLL

Medicare is our country's federal health insurance program for people age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income (SSDI) benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin.

Under the Medicare program, the hospital insurance portion is called Medicare Part A; and the medical insurance portion, such as for the cost of physicians, is called Medicare Part B.

Medicare Part A is financed by payroll taxes, and, if you are eligible to receive it based on your own--or your spouse's--employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage.

The Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) and Part B (medical benefits). This means you must enroll in **both Medicare Part A and Part B**, as soon as you are eligible for Medicare. If you do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid and you will be required to pay an additional Retiree Premium.

IMPORTANT NOTICE:

ENROLL IN MEDICARE

You must notify the Administration Office immediately upon becoming eligible for Medicare. **To be eligible for Retiree benefits under this Plan you and/or your eligible Dependent(s) are required to formally enroll in both Medicare Parts A and B and pay the required premium as soon as you and/or your eligible Dependent(s) are entitled to coverage. Note: Because Medicare benefits are assigned to your medical plan, you and/or your eligible Dependents can only enroll in one HMO Medicare Plan.**

If you elect not to enroll in Medicare (Part A and/or Part B), the Plan will charge you a monthly penalty premium in addition to the rate currently paid, until the Medicare coverage goes into effect.

It is important that you enroll in Medicare Part B when you first become eligible. If you do not, Medicare generally imposes penalties which will significantly increase your Part B premium once you do enroll. For enrollment and eligibility information, you should call Social Security at (800) 772-1213. You can also find Medicare information on the Internet at www.medicare.gov.

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

D. Methods of Payment for Retiree Coverage

You must review your agreement to determine how payments will be made for your retiree coverage. If you do not have a copy of your agreement, contact the Administration Office.

E. Retiree Health and Welfare Options

If you qualify for coverage as a normal retiree, you may select from the Medicare Medical Plan offered by this Plan, (any dependents you cover must have the same coverage as you).

If when you retire you are not eligible for Medicare, (are an early retiree, under 65) you may continue in a self-pay basis with one of the Health Plans available through the Fund. You must already be enrolled with the carrier as an active participant in order to continue as an early retiree paying the designated retiree premium

A RETIREE WHO LOSES ELIGIBILITY WILL NOT BE ABLE TO RE-ESTABLISH ELIGIBILITY

VII. MEDICAL BENEFITS

The Plan provides two medical care options. The first is Blue Shield Medical Plan. A separate booklet is available at the Administration Office which describes this coverage.

For details on your benefit coverage, please refer to Blue Shield's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Self-Funded Medical Plan and its participants.

The second option available is through an insured arrangement with Kaiser Permanente. A separate booklet is available at the Administration Office which describes this coverage.

For details on your benefit coverage, please refer to Kaiser Permanente's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Kaiser Plan and its participants.

VIII. DENTAL BENEFITS

The Plan provides dental care through an insured arrangement with Delta Dental. A separate booklet is available at the Administration Office which describes this coverage.

For details on your benefit coverage, please refer to Delta Dental's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Dental Plan and its participants.

IX. VISION CARE BENEFITS

The Plan provides vision care benefits through Vision Service Plan. A separate booklet is available at the Administration Office with complete benefit coverage, limitations, and exclusions.

For details on your benefit coverage, please refer to Vision Service Plan's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Vision Plan and its participants.

X. LIFE INSURANCE BENEFIT

The Plan provides life insurance benefits through Blue Shield. A separate Evidence of Coverage booklet is available at the Administration Office which describes this coverage.

For details on your benefit coverage, please refer to Blue Shield's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Life Insurance Plan and its participants.

XI. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

The Plan provides and Accidental Death and Dismemberment benefits through Blue Shield. A separate Evidence of Coverage booklet is available at the Administration Office which describes this coverage.

For details on your benefit coverage, please refer to Blue Shield's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the AD&D Plan and its participants.

XII. NOTICE TO THOSE ELIGIBLE FOR MEDICARE PART D

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 created a new prescription drug benefit referred to as Medicare Part D Prescription Drug Coverage (Medicare Part D coverage or coverage). The coverage is available to all Medicare eligible employees and/or dependents who are age 65 or older or are disabled and are receiving Social Security disability benefits, and those with end stage renal disease. The enrollment period for Medicare Part D is November 15th through December 31st.

A notice containing general information about Medicare Part D coverage and this Plan is required to be provided to you (a Medicare eligible individual) by the Plan prior to each annual Medicare Part D enrollment period beginning November 15, 2005. The notice must also be provided to you prior to your initial enrollment period for Medicare Part D coverage, prior to the effective date of your enrollment in this Plan, whenever the Plan's prescription drug coverage ends or changes so that it is no longer creditable, and upon your request. "Prior to" means within 12 months before the event in question.

The Plan intends to continue to provide a prescription drug benefit that is equivalent on a gross basis to Medicare Part D coverage. Therefore, there is no requirement that you enroll in Medicare Part D. The Plan will notify you if this changes.

XIII. COBRA

IF YOUR COVERAGE ENDS BECAUSE OF:	COVERAGE MAY CONTINUE FOR UP TO:
Termination of employment (for any reason other than gross misconduct) or reduction in work hours	18 Calendar Months* (*29 Calendar Months (18 Calendar Months plus an additional 11 Calendar Months), if employment ends due to termination of employment or reduction in hours, and at any time during the first 60 days of continuation coverage, the Member or his or her Dependent is totally disabled (as determined by Social Security)).
Death of Member Member's entitlement to health care coverage under Medicare Legal separation, divorce, cessation of domestic partnership Dependent Child no longer qualifies for Dependent coverage under the Plan	36 Calendar Months for Dependent

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that the Plan Participants (covered employees and dependents) be allowed to continue their medical and dental coverage under the Plan at their own expense following certain qualifying events, which request in a loss of coverage. The premium is 102% of the cost of coverage and administrative expenses.

A. Termination of Employment or Reduction in Hours

If your employment terminates or your hours are reduced so that you become ineligible for coverage, you and your eligible dependents may elect COBRA continuation coverage for up to 18 months from the date your coverage would otherwise have ended.

B. Disability-Extended Coverage

If you or an eligible dependent are determined by Social Security to be disabled within 60 days of the date on which COBRA coverage commenced, the disabled individual is entitled to extend the regular 18-month COBRA continuation coverage to 29 months. Eligible dependents of the individual electing this coverage may also receive additional coverage during this special 11-month extension. The premium for the additional 11 months of extended coverage is 150% of the cost of that coverage.

To be eligible for the special 11-month extension, the disabled individual must notify the Plan within 60 days following the later of the date on which the individual receives the initial COBRA notice following a qualifying event or the date Social Security determines that the individual is disabled and in all events before the end of the initial 18-month period of COBRA continuation coverage.

C. Dependent COBRA Coverage

Children born to you or placed with you for adoption during your continuation coverage are eligible to participate in your COBRA coverage, but there may be an additional premium required for their participation. Should you desire this additional coverage, you must promptly notify the Administration Office within 30 days at the time of birth or placement for purposes of adoption.

If you first become entitled to Medicare while on COBRA coverage which was elected following a termination of employment or a reduction in hours, your eligible dependents may elect to extend their initial 18-month COBRA continuation coverage period to 36 months from the date you initially became covered due to a COBRA election.

If your dependents lose coverage due to your death, your surviving spouse and other covered dependents may elect COBRA continuation coverage lasting for up to 36 months from the date their coverage would otherwise have ended.

If a child ceases to be eligible for benefits due to a loss of dependent status, that former dependent may elect COBRA continuation coverage lasting up to 36 months from the date his or her coverage would otherwise have ended.

If your spouse ceases to be an eligible dependent because of a divorce or legal separation, your former spouse may elect COBRA continuation coverage lasting for up to 36 months from the date your spouse's coverage would otherwise have ended.

A parent electing COBRA continuation coverage may elect to continue coverage for dependent children. An employee electing COBRA continuation coverage may elect to continue coverage for the employee's lawful spouse.

D. Cost of COBRA

If you elect COBRA continuation coverage, you must pay the cost of such coverage. The COBRA continuation coverage premiums are adjusted annually by the Plan and reflect 102% of the cost of coverage as of the date the premiums are set for the coverage. If you are totally disabled and qualify for the special extension of an additional 11 months of coverage, the premium for the 19th through 29th months of the extended coverage will be 150% of the cost of that coverage and administrative expenses.

E. Termination of COBRA Coverage

COBRA continuation coverage terminates on the earliest of the following events:

- a) The last day of the period for which COBRA continuation coverage may be elected;
- b) The date a required COBRA premium payment is due and not received by the Administration Office;
- c) The date the Plan is terminated;
- d) The date the individual receiving coverage pursuant to COBRA first becomes covered under another group medical plan, which does not contain any exclusion or limitation with respect to any preexisting condition of such person. This date may vary for different employees of the same family;
- e) The date the person on COBRA continuation coverage first becomes entitled to Medicare coverage. The right to COBRA continuation coverage terminates only for the person who becomes entitled to Medicare coverage;
- f) For individuals who are receiving the special 11-month extended coverage period due to disability, the first day of the month that begins more than 30 days after such a person is no longer disabled; and
- g) The expiration of the applicable 18-month, 29-month, or 36-month COBRA continuation period.

If your coverage ends because of the termination of employment or reduction of hours or because of your death, you or your dependents will receive information from the Administration Office within 60 days of the date of loss of coverage. The Plan will then transmit a notice of COBRA continuation rights and an application related to the coverage.

The materials transmitted by the Plan will explain your available options. The materials transmitted will also explain the application process and the premium rates applicable to coverages elected.

F. Election of COBRA Coverage

You will have at least 60 days in which to elect COBRA continuation coverage. If individuals who have lost coverage and are eligible for COBRA continuation coverage fail to make an election within the 60-day time period, rights to COBRA continuation coverage will be waived.

At the end of the COBRA continuation period elected, you may be allowed to enroll in an individual conversion health plan provided to the Plan by certain service providers (such as an HMO or insurance company). Information related to individual conversion health plans may be obtained from the specified HMO or insurance company.

If you or your spouse or dependent have COBRA continuation coverage through one of the Plan's HMO programs and you are terminated from the program because you move out the HMO's service area before the applicable COBRA period expires and the Plan does not have a contract with your HMO in that area, you or your spouse or dependent will be allowed to enroll in the group Medical Plan until the expiration of the applicable COBRA period, so long as payment of COBRA premiums are continuous and timely and the other COBRA requirements are met for the continuation of health coverage. Under no circumstances would such a transfer prolong the period of your COBRA continuation coverage. Please call the Administration Office for additional details.

In order to assure receipt of COBRA materials and other announcements describing changes in the Plan, you and your dependents should advise the Administration Office of any and all changes in your address.

Your self-payment for COBRA continuation coverage is payable on a monthly basis. It is your responsibility to pay the self-payment directly to the Administration Office in a timely fashion. You must make your first payment within 45 days after the date that COBRA continuation coverage is elected. If you fail to timely pay your COBRA premium, you will immediately lose your coverage.

XIV. FAMILY AND MEDICAL LEAVE ACT

The Federal Family and Medical Leave Act (FMLA) enacted by Congress in 1993 provides that in certain situations certain employers are required to grant leave to employees and that in such situations the employer is required to continue medical coverage for the employees.

Certain employers must continue to pay for your health coverage during any approved leave. In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

1. Your employer has at least 50 employees;
2. You worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and

3. You require leave for one of the following reasons:

- a) Birth or placement of a child for adoption or foster care;
- b) To care for your child, spouse or parent with a serious medical condition, or
- c) Your own serious health condition. Details concerning FMLA leave are available from your employer.

Requests for FMLA leave must be directed to your employer; the health plan cannot determine whether or not you qualify. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments.

If the dispute is resolved in your favor, the Plan may obtain the FMLA-required contributions from your employer and will refund the corresponding COBRA payments to you.

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

It is not the role of the Board of Trustees or the Plan to determine whether or not an individual employee is entitled to leave with continuing medical care under the applicable laws or the provisions of the agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the employer and employee.

To the extent that Participants are entitled to leave with continuing medical coverage pursuant to federal and state law or provisions contained within agreement, the Plan will provide continuing medical coverage so long as required monthly contributions are timely received from the contributing employer.

XV. RIGHTS OF STATES

Payment of benefits with respect to a participant shall be made in accordance with any assignment of rights made by or on behalf of such participant or beneficiary of a participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of that Act.

To the extent that payment has been made under a state plan for medical assistance approved under the Title XIX of the Social Security Act in any case in which the Plan has a legal liability to make payments for items or service constituting such assistance, payment for benefits under the Plan shall be made in accordance with any state law which provides that the state has acquired rights with respect to a participant to such payment for such items or services.

XVI. FEDERAL NOTICES

A. Newborns' and Mothers' Health Protection Act of 1996

Pursuant to the Newborns' and Mothers' Health Protection Act of 1996, the Plan in which you enroll may not restrict benefits for any hospital length of stay for the mother or newborn child to less than 48 hours following normal delivery or less than 96 hours following a Caesarian section delivery.

In accordance with Federal Law, those Plans may not require that a provider obtain preauthorization for either of the foregoing lengths of stay. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than the applicable time period.

B. Women's Health and Cancer Rights Act of 1998

Your Plan covers medical and surgical benefits for mastectomies. This coverage includes:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
or
3. Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

The coverage is subject to the Plan's annual deductibles and coinsurance provisions.

C. Certification of Creditable Coverage Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this Fund provide written certification of creditable coverage to you when your coverage ceases (under employer coverage and/or COBRA coverage) or when requested by you if your coverage is still in effect or if requested by you within two years after your coverage ends. The certification will specify the period(s) of creditable coverage under this Fund (including COBRA, if applicable) disregarding periods of coverage before a 63-day break. The 63-day break will not include any days between the loss of coverage and any secondary opportunity date to elect COBRA under the Trade Act of 2002.

If your coverage ends (under employer coverage and/or COBRA coverage), the certificate of creditable coverage will be provided to you automatically within a reasonable period of time after your coverage ceases. If you or someone on your behalf (including another health plan or issuer) wants to request a certificate of creditable coverage, please advise the Plan in writing at the following address:

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

You (or someone on your behalf) should provide your name and the name(s) of your dependent(s) and the address(es) to which the certificate(s) should be sent. The notice will then be processed and sent on the earliest date that the Plan, acting in a reasonable and prompt fashion, can provide it. If you request, in writing, that the Plan send the certificate to another health plan or issuer and the other plan or issuer agrees, the certificate can be processed by means other than in writing, such as by telephone.

Special Enrollment Rights

There are no special enrollment (or late enrollee) requirements under HIPAA because Employees and/or dependents cannot decline coverage under this Trust and new dependents may be added at any time subject to proof of birth, marriage, etc. One composite employer contribution is paid by the participating employer regardless of whether the employee is single, married, or has dependents.

D. HIPAA Special Enrollment Rights Under SCHIP

Effective April 1, 2009, you and your dependents may enroll in this Plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program ("SCHIP") and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or SCHIP coverage ends.

Also effective April 1, 2009, you and your dependents may also enroll in this Plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or a State Children's Health Insurance Program (ASCHIP®). However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

E. Privacy of Protected Health Information Under HIPAA

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

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

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

1. Permitted Uses and Disclosures of PHI

This Plan and its Business Associates will use and disclose PHI without your authorization for purposes of treatment, payment and health care operations, but only the minimum amount of PHI necessary to accomplish these activities. Treatment includes but is not limited to the provision, coordination or management of health care among health care providers or the referral of a patient from one health care provider to another. Payment includes but is not limited to actions concerning eligibility, coverage determinations, coordination of benefits, adjudication of health benefit claims (including appeals), determinations of cost-sharing amounts, utilization reviews, medical necessity reviews, preauthorization reviews, and billing

and collection activities. Health care operations include but are not limited to performing quality assessment reviews, implementing disease management programs, reviewing the competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes legal services and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business planning programs, and other related administrative activities.

2. Required Uses and Disclosures of PHI

This Plan must disclose PHI to you upon request to access your own PHI, with limited exceptions, or to request an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of U.S. Department of Health and Human Services (“HHS”) and its Office of Civil Rights (“OCR”) or other authorized government organizations to investigate or determine this Plan’s compliance with the Privacy Rule.

3. Agreed to Uses and Disclosures of PHI by You After an Opportunity to Agree or Disagree to the Disclosure

This Plan will disclose PHI to family members, other relatives or close personal friends if the information is directly relevant to the family or friend’s involvement with your health care or payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected.

4. Allowed Uses and Disclosures of PHI For Which Authorization or Opportunity to Object is Not Required

This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, worker’s compensation programs and correctional facilities. These uses and disclosures are more fully described in this Plan’s Privacy Policy Statement and Notice of Privacy Practices For Protected Health Information. Additional copies of these documents may be obtained from the Administration Office.

5. Your Individual Rights

HIPAA and the Privacy Rule afford you the following rights:

- You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a request. If this Plan agrees, it is bound by the restriction except when otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction.
- You (or your personal representative) have the right to request to receive communications of PHI from this Plan either by alternative means or at alternative locations. This Plan may agree to accommodate any such request if it is reasonable. This Plan, however, must accommodate such a request if you clearly state that the

disclosure of all or a part of the PHI could endanger you. You will be required to complete a request form to receive communications of PHI by alternative means or at alternative locations.

- You (or your personal representative) have the right to request access to your PHI contained in a Designated Record Set, for inspection and copying, for as long as this Plan maintains the PHI. A Designated Record Set includes the medical billing records about you maintained by or for a covered health care provider, enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for this Plan or other information used in whole or in part by or for this Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you are not in the Designated Record Set and therefore not subject to access. The right to access does not apply to psychotherapy notes or information compiled in anticipation of litigation. You must complete a request form to access PHI in a Designated Record Set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. This Plan may charge a reasonable fee for the costs of copying. If access to inspect and copy your PHI is denied, a written denial will be provided setting forth the basis for the denial, a description of how you may have the denial reviewed, if applicable, and a description of how you may file a complaint with this Plan or the HHS or its OCR.
- You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a request form to amend PHI in a Designated Record Set. This Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.
- You (or your personal representative) have the right to request an accounting of disclosures of PHI by this Plan. This Plan will provide such an accounting only for the six-year period preceding the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment or health care operations or made to you about your own PHI. Also, this Plan is not required to provide an accounting of disclosures pursuant to an authorization request or disclosures made prior to the compliance date of the Privacy Rule. You will be required to complete a request form to obtain an accounting of PHI disclosures within 60 days of the request. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the account will be provided. If more than one request for an accounting is made within a 12-month period, this Plan will charge a reasonable, cost-based fee for each subsequent accounting.

6. Access by Personal Representatives to PHI

This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but

only to the extent such PHI is relevant to their representation. For example, a personal representative with limited health care power of attorney regarding specific treatment, such as use of artificial life support, is your representative only with respect to PHI that relates to decisions concerning this treatment. The personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to take any action.

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

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

7. This Plan's Duties

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

This Plan is required by law to provide you with its Notice of Privacy Practices ("Notice") by April 14, 2003, and thereafter, upon request. Also, the Notice must be distributed by this Plan to new employees and dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

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

8. Miscellaneous

This Plan may disclose de-identified health information. Health information is considered de-

identified if it does not identify you and there is no reasonable basis to believe the information can be used to identify you, such as your name and Social Security Number.

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

This Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages its use or purchase. However, this Plan may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided under the plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.

9. Duties of the Board of Trustees With Respect to PHI

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have amended this Plan's Trust Agreement and signed a certification agreeing not to use or disclose your PHI other than as permitted by the plan documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement, Notice of Privacy Practices For Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Administration Office.

10. Complaints

If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer at the following address:

Jean P. Sukovez
United Administrative Services, Inc.
1120 Bascom Avenue
San Jose, CA 95128
Phone (408) 288-4400

A complaint may also be filed with the HHS or its OCR, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, DC 20201.

All complaints must be in writing and filed within 180 days of the date you knew or should have known of the violation. This time limit can be waived if good cause is shown. This Plan will not retaliate against you for filing a complaint.

11. Security Standards Under HIPAA

The Board of Trustees will implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of electronic protected health information that the Plan creates, receives, maintains, or transmits on behalf of the Plan. The Trustees will ensure that the adequate separation required by the Privacy Rule is supported by reasonable

and appropriate security measures. The Trustees will ensure that any agents, including a sub-contractor, to whom it provides electronic protected health information, agrees to implement appropriate safeguards to protect the information. The Trustees will report to the Plan any security incident of which it becomes aware.

XVIII. GENERAL PROVISIONS

A. Acts of Third Parties

If a Participant (including an eligible dependent) is injured through the act or omission of another party, Plan benefits are provided only on the following conditions:

1. The Participant or dependent will be required to pay to the Plan or any entity providing benefits (such as Kaiser or Blue Shield) immediately any proceeds received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance) arising out of any claims for damages by the individual or his or her heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the third party may be responsible;
2. Any Participant or dependent who accepts payments from the Plan agrees that by doing so he or she is making a present assignment of his or her rights against such third party to the extent the payments made by the Plan. These rules are automatic, but the Plan may require that any participant or dependent sign an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require; and
3. Any Participant or dependent who refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. Any Participant or dependent who receives benefit payments and later fails to reimburse the Plan as set forth above will be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the employee or dependent has failed to reimburse, including reasonable interest on such unpaid funds.

By accepting benefit payments from the Plan, any Participant or dependent agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the employee's own carrier for uninsured motorist's coverage. 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 right as described above without the Plan's written consent.

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

B. Coordination of Benefits

General Coordination of Benefits Rule: If a covered participant or dependent is entitled to benefits from another plan, the HMOs, insurance companies or other entities likely have rules on which plan is primary or secondary and who pay first. You should consult with these entities to determine the rule. The benefits provided herein shall be paid in accordance with the standardized coordination of benefits provisions of the National Association of Insurance Commissioners.

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

C. Benefit Continuation

(Amendment and Termination)

It is the intent of the Board of Trustees to continue this plan indefinitely, although the Board reserves the right to modify or discontinue this coverage at any time. Thus, benefits may be reduced or eliminated entirely. Moreover, Participants could be asked to pay a portion or the entire required premium.

D. Exclusion for Fraud

No benefits are paid for fraudulent claims or services or supplies by a covered Participant, eligible dependent or any other person. If a fraudulent claim has been paid by the Plan or by any entity on behalf of the Plan for any person, both the Participant and any person on whose behalf a fraudulent claim was submitted or paid is liable to the Plan for repayment of benefits paid and the amount of any premium paid to an HMO, PPO, insurance company or any other entity. This does not preclude the Plan, HMO, PPO, insurance company or other entity from bringing a lawsuit against any person who commits fraud to recover improperly paid benefits, services or supplies, including reimbursement for any attorney's fees and costs incurred to recover such amounts.

By way of example, if a Participant improperly signs up a person as a dependent who is not lawfully a dependent under the Plan, both the Participant and such unlawful dependent will be liable to the Plan and the Plan's providers for any claims paid, any premium paid by the Plan, and any attorneys fees and costs incurred by the Plan and any provider in recovering such improperly paid claims.

E. Claims and Appeal Procedures

Copies of the applicable appeals procedures are available from the pertinent insurance companies or other providers. The Medical Plan and Kaiser have their own appeal procedures set forth in their applicable documents.

It is required that your Health Plan provide you with specific reasons for denial of benefits and that you be given the opportunity for "full and fair review" of the denial from the provider of service (carrier).

The denial notice must include the following:

1. The specific reason(s) for the denial;
2. The specific reference to pertinent plan provisions on which a denial is based;
3. A description of any additional material or information is necessary for you to make your claim, and an explanation of why such material or information is necessary, and
4. Information on the steps to be taken if you wish to submit your claim for review.

You have at least 180 days to submit our claim for review.

A decision must be made on your initial request for a plan benefit as follows:

1. Claims for urgently needed care must be ruled on “as soon as possible”, and in no event more than 72 hours after the claim is filed;
2. Claims for pre-approval benefits must be decided upon within 15 days; and
3. Claims for reimbursement when you have already received care must be ruled on within 30 days.

Decisions on disability claims and appeals have different time periods. If the Plan denies your application for disability benefits, the Plan will notify you of the denial within 45 days after the Plan’s receipt of your application or claim.

An extension of time no exceeding 30 days may be necessary due to matters beyond the Plan’s control. If a decision cannot be rendered due to matters beyond the control of the Plan prior to the expiration of the 30 day extension, the period for making a determination may be extended for up to an additional 30 days, in which event notice will be sent to you prior to the expiration of the first 30 day extension.

In addition to the information set forth above, the notice of extension will include the standards on which entitlement to a benefit is based; the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days to provide the specified information, if any. The deadline for the Board of Trustees to render its decision is the date on which the notification of the extension is sent to you until the date a response from you is received.

The denial notice of a disability claim should include the same information as that set forth above pertaining to non-disabled claims.

Appeal

If the application for benefits or a claim is denied, you or your authorized representative may petition the Board of Trustees for review of the decision (an appeal). Your appeal must be filed with the Plan within 180 days of your receipt of the denial notification. You may have access to relevant documents, records and other information, including any statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Your appeal of the adverse benefit determination of your disability claim will be decided at the next regularly scheduled meeting the Plan's Board of Trustees following the Plan's receipt of your appeal, unless the appeal was received within 30 days of the Board meeting. If that occurs, the appeal must be decided by the following regularly scheduled Board meeting.

Finality of Decision on Claim

The denial of an application or claim after the right to review has been waived or the decision of the Board of Trustees on appeal has been issued is final and binding upon all parties, including the claimant.

When a Lawsuit may be Started

No Participant, Dependent, Beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Plan, other than as specified herein. A Participant may not start a lawsuit to obtain benefits until after either: (1) the Participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since Participant filed a request for review and Participant has not received a final decision or notice that an extension will be necessary to reach a final decision.

No lawsuit may be filed (started) more than two years after services were provided or benefits partially or totally denied or an otherwise adverse determination was made against you or, if the Claim is for short-term disability benefits, more than 2 years after the onset of the disability. The provisions of this Section shall apply to and include any and every claim to benefits from the Plan, and any claim or right asserted under the Plan or against the Plan, 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. Such claim shall be limited to benefits due to him under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive.

WARNING: BENEFITS CAN BE REDUCED OR ELIMINATED.

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

XVIII. POTENTIAL LOSS OF BENEFITS

You and/or your eligible Dependent(s) could lose your benefits and/or have payments delayed in at least the following circumstances:

A. Plan Exclusions/Co-Payments

The Plan and the insurance providers contain exclusions and exceptions for coverage. You should be aware of the Plan's and the insurance provider's limitations, exclusions, co-payments and other facets of the Plan in which you may not receive full payment on a claim or reimbursement or for which there is a co-payment.

B. Inadequate or Improper Evidence

The Plan grants the Board of Trustees the power to deny, suspend or discontinue benefits to a Participant who fails to submit at the request of the Administration Office any information or proof of coverage reasonably required to administer the Plan.

C. Subrogation Third Party Claims

The Plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible. See page 30 for Third Party Liability.

D. Coordination of Benefits

If Dependents are covered by more than one Plan, this Plan may not be responsible for many claims. Please refer to page 30 for the rules of Coordination of Benefits.

E. Work-Related Injuries

The Plan is not responsible for paying any claims incurred as a result of a work-related injury. This applies even if you have not filed a claim with workers compensation.

F. Right to Recover Claims Paid or Offset of Future Claims

The Plan has the right to recover any amounts improperly paid. The Plan may offset any amounts owed to the Plan against any claims that you and/or a Dependent incur in the future.

H. 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.

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 any benefits paid in reliance on such false statements or information. This includes but is not limited to costs incurred by the Administration Office, reasonable attorneys' fees, and interest charges. The Plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

I. Plan Termination

If the Plan terminates, benefits will no longer be provided.

XIX. GENERAL INFORMATION

(As Required by ERISA)

1. Name and Address of the Plan NECA West Health and Welfare Trust Fund

2. Type of Plan: This is a Health Care Plan, providing the following Health Care Benefits Plan –Hospital, Surgical, Medical, Dental, Vision, Life, and AD&D for active and retiree participants.

3. Type of Administration and Method of Fund Benefits: This Plan is administered by the Board of Trustees. The Plan is funded by employer contributions.

4. Sponsoring Organizations: Participating employers who contribute to the NECA WEST Health and Welfare Fund.

5. Contributions: Contributions to the plan are made by eligible employers through subscription agreements and in certain circumstances, self payment.

6. Appeal Procedure: The procedure for file appealing denials are set forth on page 31 and in the separate booklets furnished by the insurance companies and other entities.

7. Fiscal Year: The fiscal year of the Trust is the twelve-month period ending each December 31st, and the Trust's records are maintained on that basis.

8. Employer Identification Number: 23-7120690

9. Plan Number: 501

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

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

You should be provided a certificate of creditable coverage free of charge, from your group health plan or health insurance issuer as follows:

- when you leave coverage under that Plan, when you become entitled to elect COBRA continuation coverage;
- when your COBRA continuation coverage ceases;
- if you request a certificate of creditable coverage before losing coverage; or
- if you request a certificate of creditable coverage up to 24 months after losing coverage.

You may be subject to any pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the Employee Benefit Plan. The individuals who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the Plan or exercising your rights under ERISA. If your claim for benefits is denied or ignored, in whole or in part, you must receive a written explanation for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest summary annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In such a case the Court may require the Plan Administrator to provide the materials and pay you up to \$110.00 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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

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

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

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

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

11. Names and Addresses of the Board of Trustees:

Trustees:

Bart Dickson Jr. (Chairman)
Los Angeles, NECA
675 So. Arroyo Park, Ste. 300
Pasadena, CA 91105

Ru Jensen
Electro Construction
3021 Rowena Avenue
Los Angeles, CA 90030

Jason McClean
SFECA Inc.
555 Gough Street
San Francisco, CA 94102

Bernard Poggetti
Capitol Electric
480 9th Street
San Francisco, CA 94103

Patrick D'Antoni
San Mateo, NECA
1900 El Camino Real
Menlo Park, CA 94025

Darlene Besst
Nor Cal, NECA
6300 Village Parkway
Dublin, CA 94568

Michael Geller
Contra Costa Chapter, NECA
1024 Court Street
Martinez, CA 94553

Trustees:

Stephen Brown (Co-Chairman)
Orange County, NECA
P.O. Box 5210
Orange, CA 92863

Rod Anderson
Southern Sierra
17130 Van Buren Boulevard, #715
Riverside, CA 92504

Peggy Brown
NECA Orange County Chapter
P.O. Box 5210
Orange, CA 92863

Jerri Champlin
Central Coast, NECA
530 E. Main Street
Santa Maria, CA 93454

David Shankle
Southern Sierra Chapter, NECA
P.O. Box 12149
San Bernardino, CA 92423

12. Name and Address of Contract Administrator:

United Administrative Services
1120 S. Bascom Avenue
San Jose, CA 95128
Phone (408) 288-4400

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

Neyhart, Anderson, Flynn & Grosboll
Attorneys at Law
44 Montgomery Street, Suite 2080
San Francisco, CA 94104-6702
Telephone: (415) 677-9440

XX. HIPAA

In accordance with the new disclosure requirements of the Health Insurance Portability and Accountability Act, we are informing you of the names and addresses of all Health Providers for the Trust Fund and their roles (i.e., whether they guarantee the payment of benefits or provide administrative services).

List of Providers

Blue Shield of California
224 Airport Parkway
San Jose, CA 95128
Phone: (408) 288-4855
Provides prepaid life, medical and AD&D benefits with guaranteed payment of these benefits.

Delta Dental
100 First Street
San Francisco, CA 94105
(415) 977-7931
Provides prepaid dental benefits with guaranteed payment of these benefits.

Kaiser Foundation Health Plan
1800 Harrison Street, 13th Floor (North)
Oakland, CA 94120
(510) 625-3102
393 E. Walnut Street, 5th Floor (South)
Pasadena CA 91188
(626) 405-6501
Provides prepaid medical benefits with guaranteed payment of these benefits.

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

The Act also requires that we inform you of the Department of Labor address in Washington, D.C. If you have any questions about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. Additional information regarding your ERISA rights may be found in your Summary of Benefits booklet under "Statement of ERISA Rights".