

SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND

Summary Plan Description

For Eligible Active Participants
and their Eligible Dependents



As of September 1, 2017

Este folleto contiene un resumen en Inglés de su plan de derechos y beneficios del Southern California IBEW-NECA Health Trust Fund. Si usted tiene dificultad para entender cualquier parte de este folleto, comuníquese con la Oficina Administrativa al 6023 Garfield Avenue, Commerce, California 90040. Las horas de servicio son de 8:30 AM a 5:30 PM de lunes a viernes. También puede llamar a la Oficina Administrativa al (800) 824-6935 ó al (323) 221-5861 para solicitar una copia del “Summary Plan Description” en Español.

This document is also available online at www.scibew-neca.org.

**This Summary Plan Description has been restated as of
September 1, 2017**

IMPORTANT NOTICE TO ALL PLAN PARTICIPANTS

The Board of Trustees has the sole and absolute authority and discretion to interpret the provisions of this Plan and determine any and all disputed issues of fact related to eligibility under the Plan or the amount of benefits payable under the Plan. Any and all such interpretations and determinations adopted in good faith by the Board of Trustees shall be final and binding upon all parties including, but not limited to, all Participants and beneficiaries. Any such interpretation or determination may be overturned by an arbitrator or court only if such arbitrator or court finds that the Board of Trustees' interpretation or determination was arbitrary, capricious, an abuse of discretion and/or unlawful.

ATTENTION

Eligible participants and their dependents are eligible for the benefits of a Member Assistance Program, or MAP for short. This MAP provides assistance in dealing with chemical dependency, marital and family difficulties, and other urgent crisis issues. For information on the MAP, contact the Administrative Office. To access the MAP 24-hour hotline call (888) 426-0026. Please refer to Article 13: Member Assistance Program (MAP) on page 61 for more information.

NOTE

Plan ahead and familiarize yourself with the eligibility requirements of the Retiree Health Plan. Refer to Article 16: Retiree Health Plan Eligibility on page 67 for more information. There is a separate Summary Plan Description that provides complete information on the Retiree Health Plan. It is available on www.scibew-neca.org and upon request from the Administrative Office.

COLLECTION OF DOCUMENTS COMPRISE PLAN DOCUMENT

Requirements for eligibility, provisions controlling self-funded benefits and any similar items are set forth in one or more Summary Plan Descriptions and amendments thereto, and provisions controlling insured benefits are set forth in insurance policies, HMO and DMO contracts, Evidence of Coverage (EOC) and Summary of Benefits and Coverage as are in effect from time to time which all collectively along with the Trust Agreement make up the Plan Document.

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Article 1: General Information

1.1 General Contact Information

Administrative Office

Southern California IBEW-NECA Health Trust Fund

6023 Garfield Avenue
Commerce, CA 90040
(323) 221-5861
(800) 824-6935 – Nationwide
(323) 726-3520 – Fax

Mailing Address
P.O. Box 910918
Los Angeles, CA 90091

Office Hours: Monday through Friday, 8:30 a.m. to 5:30 p.m., excluding holidays

Board of Trustees

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Legal Counsel

Law Offices of Carroll & Scully, Inc.
Laquer, Urban, Clifford & Hodge LLP

Consultant

Rael & Letson, Actuaries and Consultants

1.2 Assistance

This booklet contains a summary of your Plan rights and benefits under the Southern California IBEW-NECA Health Trust Fund. It is also part of the Plan document. The Plan is set out in this document and in all of the documents listed in the section titled “Governing Benefit Documents” below.

If you have difficulty understanding any part of the Summary Plan Description, or if you have any questions, please contact the Administrative Office for assistance. We are here to help you obtain all of the benefits to which you may be entitled. Below is the necessary information to contact us.

Southern California IBEW-NECA Health Trust Fund
Administrative Office
6023 Garfield Avenue
Commerce, CA 90040
(323) 221-5861
(800) 824-6935 – Toll-free Nationwide
(323) 726-3520 – Fax
www.scibew-neca.org

Office Hours: Monday through Friday, 8:30 a.m. - 5:30 p.m., excluding holidays.

A. Governing Benefit Documents

The extent of each Active Participant's benefits is governed by the complete terms of the Southern California IBEW-NECA Health Trust Fund Plan Documents, the Evidence of Coverage, Summary of Benefits and Coverage, Insurance Contracts, and Agreements issued to the Trust Fund by the Kaiser Foundation Health Plan Inc., Southern California Region, UnitedHealthcare of California, Anthem Blue Cross of California, CIGNA Dental, Delta Dental of California, United Concordia, Vision Service Plan and Citizens Rx, and any rules and regulations for eligibility which the Trustees may adopt from time to time. This booklet describes these benefits in general terms. If there is any difference between this booklet and the Insurance Contracts, the Evidence of Coverage documents, and Agreements issued by any of the above providers, the terms and conditions of the Evidence of Coverage, Insurance Contracts or Agreements shall prevail. The Summary of Benefits and Coverage documents are distributed to Participants based upon their enrollment in the Plan. The other documents are available at the Administrative Office, or on the Trust's website, ***www.scibew-neca.org***.

B. Keep Your Records Current

Notify the Administrative Office immediately in writing of any change of address or if you have a change of dependents. **Failure to notify the Administrative Office promptly may result in ineligibility for proper benefits or liability for benefits erroneously paid.**

For example:

- You get married
- You have a new baby, adopt or become a legal guardian of a child
- You get divorced
- The death of an eligible dependent

Refer to Article 4.10: Eligible Dependents on page 21 for further information.

C. Appeals

Any appeals related to insured benefits are handled directly by the respective insurance company. Please refer to the insurance vendor's Evidence of Coverage booklet for the claims and appeals procedures pertaining to each benefit plan.

The Fund Office makes all initial determinations as to basic eligibility under Article 4, COBRA and comparable eligibility provisions of this document. Appeals of denial of eligibility by the Fund Office are handled by the Board of Trustees upon timely notification to the Administrative Office. Individuals will be notified in writing of all adverse determinations as to eligibility and appeal decisions within the time required by federal law and regulations.

Citizens Rx is a claims fiduciary and handles Prescription Drug claims and appeals under its claims and appeal rules. Citizens Rx will decide appeals and obtain independent medical reviews requested by Participants. Citizens Rx will use an IMR company licensed in the State of California. Participants will be notified in writing of any adverse determinations within the time required by federal law and regulations.

Coast Benefits, Inc. is a claims fiduciary and handles all Medical Body Scan claims, Specialized Footwear claims and Health Reimbursement Arrangement claims under its claims and appeal rules. In the unlikely event that a claim is denied based upon a lack of medical necessity and an appeal brought, Coast Benefits, Inc. will use an IMR company licensed in the State of California for any appeals related to medical necessity issues. Participants will be notified in writing of any adverse determinations within the time required by federal law and regulations.

For more information on appeals, see Article 18.2: Claims and Appeal Rules on page 85.

Article 2: Plan Benefits Available to You

2.1 Inside Wireman, Intelligent Transportation, Inspector, Railroad Agreements

- ▶ Hospital/Medical Benefit Options (Choice of One)
 - Anthem Blue Cross PPO Plan
 - Kaiser HMO Plan
 - UnitedHealthcare HMO Plan
- ▶ Dental Benefit Options (Choice of One)
 - United Concordia Preferred Provider Organization (PPO) Plan
 - CIGNA Dental Health Maintenance Organization (DHMO) Plan
 - DeltaCare USA Dental Health Maintenance Organization (DHMO) Plan
 - United Concordia Dental Health Maintenance Organization (DHMO) Plan
- ▶ Prescription Drug Benefit Options
 - Citizens Rx
- ▶ Health Reimbursement Arrangement
(Only Inside Wireman, Intelligent Transportation and Railroad Agreements—not available for Inspectors)
- ▶ Vision Care Benefit Options
 - Vision Service Plan (VSP)
(UnitedHealthcare HMO and Anthem Blue Cross PPO Plan Participants)
 - Kaiser Vision Plan
(Except prescription safety glasses, which are provided through VSP for Employees only)
- ▶ Body Scan Benefits
 - Body Scan International
- ▶ Orthotic Benefits
- ▶ Advocacy and Assistance Benefit
 - MedExpert
- ▶ Member Assistance Program (MAP)
- ▶ Life Insurance/AD&D Benefits
 - Anthem Blue Cross Life and Health Insurance Company
- ▶ Retiree Health Benefits

2.2 Residential Agreement

- ▶ Hospital/Medical Benefit Options (Choice of One)
 - Anthem Blue Cross PPO Plan
 - Kaiser HMO Plan
 - UnitedHealthcare HMO Plan
- ▶ Dental Benefit Options (Choice of One)
 - United Concordia Preferred Provider Organization (PPO) Plan
 - CIGNA Dental Health Maintenance Organization (DHMO) Plan
 - DeltaCare USA Dental Health Maintenance Organization (DHMO) Plan
 - United Concordia Dental Health Maintenance Organization (DHMO) Plan
- ▶ Prescription Drug Benefit Options
 - Citizens Rx
- ▶ Vision Care Benefit Options
 - Vision Service Plan (VSP)
(Available to UnitedHealthcare HMO and Anthem Blue Cross PPO Plan Participants)
 - Kaiser Vision Plan
(Except prescription safety glasses, which are provided through VSP for Employees only)
- ▶ Body Scan Benefits
 - Body Scan International
- ▶ Orthotic Benefits
- ▶ Advocacy and Assistance Benefit
 - MedExpert
- ▶ Member Assistance Program (MAP)
- ▶ Life Insurance/AD&D Benefits
 - Anthem Blue Cross Life and Health Insurance Company

2.3 9th District Sound and Communications Agreement

- ▶ Hospital/Medical Benefit Options (Choice of One)
 - Anthem Blue Cross PPO Plan
 - Kaiser HMO Plan
 - UnitedHealthcare HMO Plan
- ▶ Dental Benefit Options (Choice of One)
 - United Concordia Preferred Provider Organization (PPO) Plan
 - CIGNA Dental Health Maintenance Organization (DHMO) Plan
 - DeltaCare USA Dental Health Maintenance Organization (DHMO) Plan
 - United Concordia Dental Health Maintenance Organization (DHMO) Plan
- ▶ Prescription Drug Benefit Options
 - Citizens Rx
- ▶ Vision Care Benefit Options
 - Vision Service Plan (VSP)
(UnitedHealthcare HMO and Anthem Blue Cross PPO Plan Participants)
 - Kaiser Vision Plan
(Except prescription safety glasses, which are provided through VSP for Employees only)
- ▶ Body Scan Benefits
 - Body Scan International
- ▶ Orthotic Benefits
- ▶ Advocacy and Assistance Benefit
 - MedExpert
- ▶ Member Assistance Program (MAP)
- ▶ Life Insurance/AD&D Benefits
 - Anthem Blue Cross Life and Health Insurance Company

2.4 Material Handlers Agreement

- ▶ Hospital/Medical Benefit Options (Choice of One)
 - Anthem Blue Cross PPO Plan
 - Kaiser HMO Plan
 - UnitedHealthcare HMO Plan
- ▶ Prescription Drug Benefit Options
 - Citizens Rx
- ▶ Body Scan Benefits
 - Body Scan International
- ▶ Orthotic Benefits
- ▶ Advocacy and Assistance Benefit
 - MedExpert
- ▶ Member Assistance Program (MAP)

2.5 Maintenance Agreement

- ▶ Hospital/Medical Benefit Options (Choice of One)
 - Anthem Blue Cross PPO Plan
 - Kaiser HMO Plan
 - UnitedHealthcare HMO Plan
- ▶ Prescription Drug Benefit Options
 - Citizens Rx
- ▶ Body Scan Benefits
 - Body Scan International
- ▶ Orthotic Benefits
- ▶ Advocacy and Assistance Benefit
 - MedExpert
- ▶ Member Assistance Program (MAP)
- ▶ Life Insurance/AD&D Benefits
 - Anthem Blue Cross Life and Health Insurance Company

2.6 9th District Sound and Communications Agreement 45% and 50% Apprentices

- ▶ Hospital/Medical Benefit
 - Alternate Kaiser HMO Plan Only
- ▶ Prescription Drug Benefit Options
 - Citizens Rx
- ▶ Advocacy and Assistance Benefit
 - MedExpert
- ▶ Member Assistance Program (MAP)
- ▶ Life Insurance/AD&D Benefits
 - Anthem Blue Cross Life and Health Insurance Company

The Board of Trustees recognizes that certain Sound Unit Apprentices (45% and 50%) receive contributions to the Plan at a substantially reduced contribution rate than that provided for other classifications of participants in the Plan, resulting in a significant proration of those contributions which effectively prohibited the apprentice from ever gaining eligibility.

A separate set of benefits are provided exclusively through Kaiser for the Sound Unit 45% and 50% apprentices only. Refer to Article 6.2: 45% and 50% Sound Apprentice – Kaiser Permanente on page 34 for more information. None of the other benefits described in this SPD are available to eligible Sound Unit 45% and 50% Apprentices and their dependents. However, the non-benefit provisions, such as definitions, COBRA rights and appeal rights do apply.

Upon graduation to a 55% Sound Unit Apprentice level or higher, the hours remaining in the Hours Bank Reserve for the Alternate Kaiser Plan benefit will be transferred to the Active Hours Bank Reserve. The Participant will be transferred to the Active Kaiser HMO Plan of benefits and will remain enrolled in that plan for a minimum of 12 months and the participant will receive documentation from the Administrative Office regarding the additional benefits available at the time of transfer to the Active Kaiser HMO Plan.

Article 3: General Plan Definitions

3.1 Advocacy and Assistance Benefit

An advocacy and assistance service whereby Personal Health Advocates (PHAs) are available to aid in locating physicians, resolution of billing disputes, facilitate referrals for covered services, assist with the transfer of medical records, locate elder/childcare facilities, and more. See Article 12: Advocacy and Assistance Services Program on page 60 for more information.

3.2 Association

Los Angeles County Chapter of the National Electrical Contractors Association (“NECA”).

3.3 COBRA

The federal law requiring the continuation of group health coverage when eligibility or coverage ends as provided for by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended from time to time and by all applicable regulations.

3.4 Collective Bargaining Agreement

Any Agreement between the Association and the Union which requires Contributions to the Southern California IBEW-NECA Health Trust Fund and any other Collective Bargaining Agreement requiring Contributions to the Plan approved by the Board of Trustees.

3.5 Contributions

The payment made or to be made to the Southern California IBEW-NECA Health Trust Fund by any individual Employer under the provisions of any of the Collective Bargaining Agreements. The term "Contributions" shall also include a payment made on behalf of an Employee of a Local Union or other contributing Employer pursuant to a Subscription or Participation Agreement approved by the Board of Trustees.

3.6 Covered Employment

Work at a job for which Contributions are required under a Collective Bargaining Agreement.

3.7 Credited Hour

Credited Hours, Hours Worked and Hours means work hours reported under Covered Employment for which Contributions are actually received. Contributions for Hours Worked in Covered Employment received more than three (3) months subsequent to the month in which the hours were actually worked are credited to your Hours Bank Reserve in the month the Contributions were received rather than being credited as Hours Worked in the month the work was actually performed. These delinquent Employer Contributions are credited to your Hours Bank Reserve because various contracts with service providers prohibit the Fund from providing

you with retroactive eligibility. The normal 600-hour limit for your hour bank does not apply to the extent the delinquent hours are credited to your Hours Bank Reserve.

The term Credited Hour and/or Hours Worked also includes any pro-rated hour that is worked by an Employee for which Contributions are paid to a Health Fund which is signatory to the International Brotherhood of Electrical Workers (IBEW) Reciprocal Agreement to the extent such reciprocal Contributions are received by this Fund.

Reciprocal Contributions, delinquent Contributions and Contributions received under certain Collective Bargaining Agreements are converted to hours under this Plan by dividing the monies received by the then existing hourly Contribution rate under the IBEW Local 11 Inside-Wiremen's Collective Bargaining Agreement. See Article 4.4: I.O. Health Reciprocal Agreement and Proration Under Certain Collective Bargaining Agreements on page 15 for more information.

3.8 Dependent

Eligible dependents under this Plan are the legal spouse of the Participant and the Participant's children (including step children or legally adopted children) under 26 years of age. Refer to Article 4.10: Eligible Dependents on page 21 for more information.

3.9 Electrician

Includes any Employee who works in any classification covered by a Collective Bargaining Agreement participating in this Plan, negotiated between a participating IBEW Local and a participating NECA Chapter.

3.10 Employee

An Employee of an Employer (as defined below) who works in Covered Employment and satisfies the rules of eligibility adopted by the Fund.

3.11 Employer

Any individual Employer signatory to any Agreement with the Union and the Association, which requires Contributions by the Employer into this Trust Fund. The term "Employer" also includes the Union and other contributing Employers pursuant to regulations adopted by the Board of Trustees.

3.12 Family Member

A Participant's Spouse or Dependent Child of an Employee.

3.13 Health Reimbursement Arrangement

Additional benefits provided to eligible participants and their eligible dependents for qualified medical expenses that are not covered by this Plan or any other health plan. See Article 7: Health Reimbursement Arrangement on page 38 for more information.

3.14 Hours Bank Reserve

The Hours Bank Reserve is merely an eligibility device. A Participant's individual Hours Bank Reserve is in no fashion a vested right and the Hours Bank Reserve is in no fashion pre-funded. The provisions of the Hours Bank Reserve governing eligibility may be eliminated or amended at any time by the Board of Trustees in the sole discretion of the Board of Trustees.

3.15 Member Assistance Program (MAP)

The Integrated Member Assistance Program is a managed care program administered by OptumHealth. The MAP benefit is a free confidential counseling and referral service to help assess a variety of personal problems and suggest ways to resolve them. See Article 13: Member Assistance Program (MAP) on page 61 for more information.

3.16 Participant and/or Plan Participant

The term "Participant" applies to the employee who has met the eligibility requirements for benefits under this Plan.

3.17 Qualifying Event

A Qualifying Event for continuation coverage occurs when a qualified beneficiary loses coverage under this Plan under circumstances defined in COBRA. This entitles the qualified beneficiary to elect to continue coverage under the Plan by self-payment. See Article 17.1: COBRA for more information.

3.18 Summary Plan Description and/or SPD

The Summary Plan Description provides you with various information as to eligibility and certain information required by law. It also serves as part of the Plan document. The Evidence of Coverage documents and the insurance policies provide you with additional detailed information as to specific benefits under the benefit options available under the PPO or HMO plans you elect.

3.19 Trust Agreement

The Agreement and Declaration of Trust establishing the Southern California IBEW-NECA Health Trust Fund and any modification, amendment, extension, or renewal thereof.

3.20 Trustee and/or Board of Trustees

As defined in the Agreement and Declaration of Trust establishing the Southern California IBEW-NECA Health Trust Fund.

3.21 Trust Fund and/or Plan

The Southern California IBEW-NECA Health Trust Fund.

3.22 Union and/or Local Union

The International Brotherhood of Electrical Workers (IBEW), AFL-CIO, Local 11.

Article 4: Eligibility and General Plan Provisions

4.1 Eligibility: When Coverage Begins

Eligibility for coverage for Active Employees is based on your working a certain minimum number of hours as explained below with one or more Employers who actually make Contributions to the Fund on your hours of employment.

Even if a Participant's Hours Bank Reserve contains sufficient hours for initial eligibility, the only benefit a Participant will have until he or she completes an enrollment form for one of the medical options and one of the dental options will be Life and AD&D insurance. Even if the Participant fails to return the enrollment forms to the Administrative Office in a timely fashion, the Participant's Hours Bank Reserve will be charged as if the Participant has completed all the steps required for enrollment in the benefits offered by the Plan. However, the Participant will have no actual coverage (except for Life and AD&D insurance) until the Participant has completed all the steps required for enrollment in benefits offered by the Plan. The Participant's failure to take appropriate action in enrolling for benefits will cause a reduction in the Participant's Hours Bank Reserve without providing the Participant with benefits or coverage, which would exist if the Participant enrolled in the benefit options available to him or her on a timely basis.

Important: See Article 4.7: Designated Working Members (DWM) on page 19 and Article 4.13: Cancellation of Eligibility and Termination of the Hours Bank Reserve (Trust Agreement Non-Compliance and Contribution Reporting Requirements) on page 23 for more information.

4.2 Working Local 11 Electricians

You will be eligible for benefits under the Southern California IBEW-NECA Health Trust Fund the first day of the third month, following receipt of 100 hours of contributions at the rate established from time to time by the IBEW Local 11 Inside Wiremen's Agreement on your behalf within four (4) consecutive months. The process is shown by the following examples:

Example 1: You work 100* hours in January and the employer(s) reported and paid contributions in February. You will be eligible for benefits on May 1st.

*Check agreements for the number of hours required; See Article 4.4: I.O. Health Reciprocal Agreement and Proration Under Certain Collective Bargaining Agreements for more information.

Example 2: You work 25 hours in January, February, March and April and the employer(s) reported and paid the contributions in February, March, April and May. By the end of May, you have worked 100 hours and the contributions have been received on your behalf, and you will be eligible for coverage August 1st.

If you do not achieve eligibility within a four (4) consecutive month period, your then accrued hours shall be cancelled. This process is shown by the following example:

Example: In January, February, March and April you work 24 hours in each month. Your employer(s) reported and paid all contributions in February, March, April and May. You have no other hours in your Hours Bank Reserve. Because your total hours do not equal 100 hours in a 4-consecutive month period you did not achieve eligibility and the oldest month's hours are cancelled. The new 4-month period to accumulate hours for eligibility in the above example will be the work months of February, March, April, and May.

The table set forth below reflects ongoing eligibility based upon hours worked in particular months.

For Example: 100 Hours Worked In	Gives Eligibility In
July	November
August	December
September	January
October	February
November	March
December	April
January	May
February	June
March	July
April	August
May	September
June	October

The foregoing table presumes that the contributions for the hours you worked are actually received by the Southern California IBEW-NECA Health Trust Fund. Contributions must be received in order for eligibility to be provided.

4.3 Hours Bank Reserve

Hours Worked in excess of 100 hours per month will be added to your Hours Bank Reserve. The maximum you can accumulate in your Hours Bank Reserve account is 600 hours. Your eligibility will continue as long as your reserve account contains at least 100 hours.

You will continue to maintain your Hours Bank Reserve for each month that you are eligible for coverage by working in Covered Employment, and/or continuation of eligibility from your Hours Bank Reserve, or continuation of eligibility by making a COBRA self-payment.

If your Hours Bank Reserve falls below 100 hours and you are not eligible for benefits for four (4) consecutive months your Hours Bank Reserve will be canceled. In no event, shall any month in which you receive California SDI benefits or workers' compensation temporary disability benefits or any month in which delinquent Contributions, except for certain delinquent

contributions, owed to your account and not previously credited to you are being pursued be included within the calculation of these four (4) consecutive months.

4.4 I.O. Health Reciprocal Agreement and Proration Under Certain Collective Bargaining Agreements

It is recognized that some Participants fail to qualify for Health coverage because they travel out of the geographic area covered by the Plan. In accordance with national I.O. Guidelines, contributions received from another Health Fund that participates in the I.O. Health Reciprocity Agreement will be credited to the Employee as hours worked. To be eligible for this reciprocity program you must have:

- 1) been eligible under this Plan within six (6) years of the first work month included in the contribution transfer or;
- 2) be a newly organized member of I.B.E.W. Local 11 prior to the date of contribution transfer or;
- 3) moved your ticket to I.B.E.W. Local 11 prior to the date of contribution transfer.

When the hourly rate of contributions being transferred to this Plan is less than the hourly rate of contributions paid directly to this Plan under the Inside Wireman's collective bargaining agreement in effect at the time of the contributions transfer, the hours credited to you under this Plan will be prorated in accord with the example shown below. The same method of proration shall apply to provisions in CBAs calling for contributions lower than the standard rate. The Administrative Office can advise you of CBAs subject to this provision.

For example, if a Participant works 150 hours in a reciprocal area where the hourly Health contribution rate is \$8.11, and the Employee designates Local 11 as the Home Fund, with a current hourly Health contribution rate of \$11.49 (Inside Wireman's Agreement) the hours would be prorated as follows:

$$\text{Participating local rate } \$8.11 / \text{Home local rate } \$11.49 = 70.5831\%$$

$$150 \text{ hours} \times 70.5831\% = 105.8746 \text{ credited Health hours.}$$

Note: There are periodic changes in the employer contribution rate. Check with the Administrative Office for the current rate for your reciprocal area and for the current home local rate.

All reciprocal Contributions received by this Plan more than three (3) calendar months from the close of the month in which the hours were actually worked shall be credited as Hours Worked three (3) calendar months prior to the month in which the Contributions are received rather than the month in which the hours are worked. However, the hours will be applied to the month in which the hours were actually worked if doing so would provide eligibility by work hours for a month for which a COBRA continuation of coverage payment was made and that COBRA continuation payment shall be refunded.

Example: Hours Worked in January and received in April would be credited as worked in January. Hours Worked in January and received in May would be credited as worked in February.

4.5 Workers' Compensation, Temporary Disability Benefits or California State Disability Insurance

Crediting of Hours and Maximum Credit: An Employee will be given 40 hours of work credit for each week of approved Workers Compensation disability, up to a maximum of 26 weeks per temporary disability.

Hours will be credited toward your eligibility, in the same manner as described under Article 4.2: Working Local 11 Electricians on page 13. For example, if you are unable to work for three (3) weeks in July, and have received 120 hours of disability credit, it will apply towards your November eligibility.

Solely for purposes of establishing eligibility for the crediting of hours under this provision, hours worked for which contributions are being reciprocated to the Plan under the I.O. Health Reciprocity Agreement shall be considered hours worked in Covered Employment and the employer generating those reciprocal contributions shall be considered a signatory Employer to the Trust Fund.

NOTE: Periods for which you received California State Disability Insurance for non-work related injuries do not result in any crediting of hours. However, periods of receipt of these 'SDI' benefits can prevent forfeiture of Hours Bank Reserve balances of less than 100 hours.

Workers Compensation	State Disability
Eligibility Requirements	Eligibility Requirements
You must have been eligible for Plan benefits in the month in which the occupational injury occurred and had contributions paid to this Plan on your behalf by an Employer.	You must have been eligible for Plan benefits in the month immediately preceding the first of the four (4) consecutive months of preserved hours.
Provide written notice to the Administrative Office within 30 days from the date your eligibility ends.	Provide written notice to the Administrative Office within 30 days from the date your eligibility ends.
Provide proof of disability and the time period of disability (i.e. Workers' Compensation award letter, Workers' Compensation benefit paystubs for the time period of disability).	Provide proof of disability and the time period of disability (i.e. proof that you are receiving SDI benefits).
Benefits	Benefits
Maximum of 1,040 hours (40 hrs/wk; 26 weeks x 40 = 1,040 hours)	Hours Bank Reserve below 100 hours will be preserved for four (4) consecutive months.
You will be given 40 hours of work credit for each week of approved Workers Compensation temporary disability benefits, up to the maximum benefit of 26 weeks.	No month in which you receive SDI benefits or delinquent contributions are being pursued will be included in the four (4) consecutive months.
NOTE: The hours credited are Health hours only.	NOTE: Prompt notification of your receipt of State Disability benefits will protect your Hours Reserve Bank.

4.6 Initial Eligibility for Certain Employees of Certain New Contributing Employers

The following describes the conditions under which an Employee may be granted initial eligibility if working in Covered Employment for a new contributing Employer.

- A. For purposes of this rule, a “new contributing Employer” is an Employer who has been providing medical coverage to its Employees from a source other than the Plan and who entered into a Collective Bargaining Agreement requiring Contributions to the Plan.
- B. For purposes of this rule, an “eligible Employee” is an Employee who meets all of the following requirements:

1. The Employee was employed by the Employer immediately prior to the effective date of the Collective Bargaining Agreement.
 2. The Employee was receiving medical coverage from the Employer immediately prior to the effective date of the Collective Bargaining Agreement.
 3. The Employee following the effective date of the Collective Bargaining Agreement remains in the employ of the Employer and performs work for which Contributions are payable to the Plan pursuant to the Collective Bargaining Agreement.
 4. The Employee has no pre-existing Hour Bank Reserve under this Plan as of the effective date of the Collective Bargaining Agreement.
- C. An eligible Employee of a new contributing Employer shall be granted an initial Hours Bank Reserve equivalent to four (4) months of coverage. In order to off-set this initial Hours Bank Reserve, an equivalent amount of hours of the first Hours Worked per month in excess of the hours required for monthly eligibility will not be credited to the eligible Employee's Hours Bank Reserve. If the initial eligibility is granted after the close of the first workweek of a particular month, the initial Hours Bank Reserve granted shall be equivalent to five (5) months of coverage, and an equivalent amount of the first Hours Worked per month in excess of the hours required for monthly eligibility will not be credited to the eligible Employee's Hours Bank Reserve in order to off-set the initial hour bank granted.
- D. Only collective bargaining unit Employees may be granted initial eligibility under this rule.
- E. In the event an eligible Employee granted an initial Hours Bank Reserve pursuant to sub-section (C) terminates employment, whether voluntary or involuntary, prior to working in Covered Employment at least the number of hours credited pursuant to sub-section (C), all benefits of that Employee and their Dependents under this Plan shall terminate as of the first day of the month following the month in which the employment terminated. An Employee granted an initial Hours Bank Reserve pursuant to sub-section (C) and their Employer must give prompt written notice of termination of employment to the Administrative Office. Employees and their Dependents losing eligibility pursuant this Section shall be offered non-subsidized COBRA coverage and conversion rights to the extent required by applicable law. Should the Employee return to Covered Employment or sign the out-of-work book of IBEW Local 11 within five (5) business days of the termination of employment, no loss of eligibility shall occur under this sub-section.
- F. Should the termination be for reasons of injury or illness for which Workers' Compensation temporary disability benefits or California State Disability benefits are payable, no loss of eligibility shall occur under this sub-section unless and until the Employee recovers and then only if the Participant then fails within five (5) business days to return to Covered Employment or sign the out-of-work book of IBEW Local 11.
- G. Should the termination be due to Participant taking a leave of absence in accord with applicable Family Medical Leave Act ("FMLA") laws, no loss of eligibility shall occur

under this sub-section unless and until the Employee completes the authorized leave and then only if the Participant then fails within five (5) business days to return to Covered Employment or sign the out-of-work book of IBEW Local 11.

- H. Should the termination be due to the Participant being called into active military service, no loss of eligibility shall occur under this sub-section, and coverage shall be continued to the extent otherwise provided for under this Plan.

4.7 Designated Working Members (DWM)

Designated Working Members (also referred to as “Working Electrical Contractors or DWM”) are working electricians who are owners, partners, or corporate officers.

To be eligible, the DWM must report and pay a minimum of 153 hours per month. Importantly, the annual maximum hours reported will be 2,500. (NOTE: The minimum of 153 hours per month must be reported and paid BEFORE proration. See Article 4.4: I.O. Health Reciprocal Agreement and Proration Under Certain Collective Bargaining Agreements on page 15 for more information.)

For Example:	
<u>153 Hours Worked In</u>	<u>Gives Eligibility In</u>
July	November
August	December
September	January
October	February

Limited to 2,500 reported hours per year

A DWM may decline initial enrollment. However, the DWM cannot request that the Plan accept contributions from the Employer on his or her behalf as a DWM until at least 12 months after the month in which the declination to participate in the Health Plan is received by the Administrative Office. All other contributions due under the Collective Bargaining Agreement are to be paid by the Employer, even if you decline to participate in the Plan.

If the DWM declines to participate during the initial enrollment period and later elects to participate in the Plan, the DWM will be limited to the medical and dental HMO options available under this Plan (refer to the section titled “Plan Options”) for at least 12 months after becoming eligible. After at least 12 months of continuous participation in the Plan, medical and dental carrier changes, including a change to PPO medical and dental plans, will be permitted under the Plan’s rolling 12-month open enrollment rule.

The eligibility of a DWM, will be canceled if such Employer is in non-compliance with the Trust Agreement contribution reporting requirements. The Administrative Office will provide a notice to the DWM that their Employer is in non-compliance with the contribution provisions of the Trust Agreement.

Effective the first of the month, following 45 days after receipt of such notice due to non-compliance with the Contribution provisions of Collective Bargaining Agreements, the eligibility

and Hours Bank Reserve will be terminated. If the delinquent payment status is corrected within the 45-day period, the Hours Bank Reserve will be restored.

The Hours Bank Reserve may not be utilized for continuing coverage during periods when a DWM finds other employment outside of the Plan and declines coverage available due to that employment in order to receive increased wages for that employment.

Note: DWMs are not eligible for subsidized COBRA benefits.

4.8 Alumni Agreement

A signatory Employer will be permitted to make Contributions to the Plan on behalf of the Employer's non-bargained Employees who previously were collectively bargained employees under the terms of a Collective Bargaining Agreement which required Contributions to the Plan and for whom the Employer has agreed to make Contributions to the Plan pursuant to a duly executed Alumni Participation Agreement. The Employer shall make Contributions to the Plan on behalf of each Alumni reported under the Alumni Participation Agreement at a rate of 173 hours per month at the hourly Contribution rate for journeymen as set forth in the Inside Agreement, as may be amended from time to time. Initial eligibility and coverage for all such Alumni shall occur in the same manner described in Article 4.2: Working Local 11 Electricians on page 13.

Hours reported in excess of 100 hours per month will be added to your Hours Bank Reserve. The maximum you can accumulate in your Hours Bank Reserve account is 600 hours. Your eligibility will continue as long as your Hours Bank Reserve account contains at least 100 hours. In no event, will reserve hours accrued as an Alumni and reserve hours accrued while a working Local 11 Electrician exceed a total of 600 hours.

4.9 Participation Agreement

The following describes the conditions by which an Employee may be granted initial eligibility under the terms of certain Participation Agreements.

An eligible Employee gaining eligibility under certain Participation Agreements may be granted an initial Hours Bank Reserve equivalent to four (4) months of coverage. In order to offset this initial Hours Bank Reserve, an equivalent amount of hours of the first Hours Worked per month in excess of the hours required for monthly eligibility will not be credited to the eligible Employee's Hours Bank Reserve. If the initial eligibility is granted after the close of the first workweek of a particular month the initial Hours Bank Reserve granted shall be equivalent to five (5) months of coverage and an equivalent amount of the first Hours Worked per month in excess of the hours required for monthly eligibility will not be credited to the eligible Employee's Hours Bank Reserve in order to off-set the initial hour bank granted.

In the event an eligible Employee granted an initial Hours Bank Reserve terminates employment, whether voluntary or involuntary, prior to working at least the number of hours credited pursuant to this section, all benefits of that Employee and their Dependents under this Plan shall terminate as of the first day of the month following the month in which the employment terminated.

An Employee granted an initial Hours Bank Reserve pursuant to this section and their Employer, must give prompt written notice of termination of employment to the Administrative Office, pursuant to the Participation Agreement. Employees and their Dependents losing eligibility due to the termination of their employment prior to working the number of hours credited, shall be offered non-subsidized COBRA coverage and conversion rights to the extent required by applicable law.

4.10 Eligible Dependents

The following table summarizes who may be enrolled in the Plan as an eligible dependent and the documentation required by the Administrative Office to process the enrollment. An eligible dependent may be covered under all benefits available to the Participant. Eligibility for benefits will continue in the case of dependent children up to the limiting age shown in the table below; eligible dependent children will continue to be covered for dependent life insurance benefits to age 26. An eligible Dependent includes any child for whom the Participant is the legal guardian or for whom the eligible Spouse of a Participant is the legal guardian. A detailed explanation of the eligibility requirements under the Plan follows this table.

Eligible Plan Participants	Required Documentation
Spouse	Copy of Marriage Certificate
Biological Children to age 26	Birth Certificate/Paternity Test/QMCSO
Step Children to age 26	Birth Certificate
Adopted Children to age 26	Adoption Affidavit
Permanently Disabled Children	Birth Certificate/Paternity Test/ Adoption or Guardianship Affidavit
Child who is a ward under order of temporary or permanent guardianship	Legal Guardianship
Temporarily Disabled Child	Disability Application/Birth Certificate – Child subject to Temporary or Permanent Guardianship

Under this Plan, eligible Dependents are the legal spouse (this Plan does not recognize a common law spouse unless the common law marriage was established in a jurisdiction which permits the creation of common law marriages) of the Participant as described in the following section and the Participant's children (including a step child or a legally adopted child) under 26 years of age. As required by law, an eligible Dependent will include a child under age 18, when placed with an Employee for adoption. Coverage for a Participant's children will terminate at the end of the month in which the child reaches age 26, unless otherwise extended under the provisions of this Plan. An eligible Dependent includes any stepchild of the Participant, who is under 26 years of age, who depends upon the Participant for support and lives with the Participant in a regular parent-child relationship and is a dependent of the Participant within the meaning of Internal Revenue Code Section 152.

Participants must provide written proof to the Administrative Office of their legal dependents in order for Dependents to be eligible for the benefits of this Plan. For example, a copy of your marriage certificate for a spouse, a copy of a birth certificate for a child and a copy of a decree of adoption for an adopted child. Once enrolled, coverage for the Participant's children under age

26 and the lawful spouse under this Plan is not optional. There is no ability to subsequently terminate coverage under this Plan for enrolled eligible Dependents of any eligible Participant so long as the Dependent continues to be an eligible Dependent. Nothing in this Article is intended to modify the carrier's coordination of benefits provisions.

Dependent children of eligible participants are covered for life insurance benefits from birth to age 26.

If a child covered by this Plan becomes totally and permanently disabled prior to reaching his/her 26th birthday while dependent upon his/her parents for support, his/her eligibility shall be continued for the duration of his/her disability, under the member's eligibility.

Upon dissolution, divorce, legal separation, or annulment, a spouse ceases to be an eligible Dependent on the first day of the month following the month in which the final decree terminating the marital relationship, or providing for the legal separation, is issued. However, a spouse may continue to be eligible as a qualified beneficiary under this Plan if COBRA continuation coverage is timely elected, as more fully set forth in the COBRA section of this Plan. In order to avoid liability for benefit expenses of ineligible dependents, you should notify the Administrative Office of a dissolution, divorce, or annulment as soon as it occurs.

4.11 Non-Covered Electrical Employment

If after attaining eligibility under this Plan, a Participant engages in Non-Covered Electrical Employment as that term is defined in Section 1.16 of the Southern California IBEW-NECA Pension Plan, or is employed by an employer in the same industry as any Employer that contributes to this Plan, if the Participant's employer is not a contributing Employer to this Plan or any IBEW-sponsored Trust Fund, such Participant will lose eligibility under this Plan and shall not be entitled to further coverage under this Plan or any coverage under the Southern California IBEW-NECA Retiree Health Plan. In such event, a Participant who has engaged in Non-Covered Electrical Employment and his or her Dependents shall lose eligibility and the accumulated Hours Bank Reserve shall be canceled on the last day of the month in which Non-Covered Electrical Employment is discovered by the Administrative Office. A Participant and his or her Dependents losing eligibility pursuant to this Section shall be offered non-subsidized COBRA coverage and conversion rights, if any, to the extent permitted by applicable law and the rules of this Plan and Summary Plan Description.

However, a Participant whose eligibility for coverage under this Plan was terminated as a result of that Participant having engaged in Non-Covered Electrical Employment shall be permitted to reinstate eligibility for coverage hereunder if a Participant returns to Covered Employment in accordance with the General Eligibility requirements.

The Hours Bank Reserve shall immediately terminate for Employees employed by an Employer, who ceases Contributions to this Plan pursuant to the termination of such Employer's Collective Bargaining Agreement.

4.12 Termination or Reduction of Coverage:

- A. A Participant's coverage will terminate on the earliest date of any of the following:
 - 1. On the date the Participant loses eligibility (including loss of eligibility as described under Article 4.7: Designated Working Members (DWM) on page 19 and Article 4.11: Non-Covered Electrical Employment on page 22).
 - 2. Upon the termination of any coverage. For example, a Plan is terminated.
- B. The benefits for a dependent will terminate when the Participant's eligibility terminates or earlier when the Dependent no longer meets the definition of Dependent as provided above under Article 4.10: Eligible Dependents on page 21.

Exception: If the termination is due to the death of the Participant, the benefits for his eligible Dependents shall continue until such deceased Participant's Hours Bank Reserve, if any, has been exhausted.

NOTE: None of the conditions identified above alter the provisions as set forth in Article 4.13: Cancellation of Eligibility and Termination of the Hours Bank Reserve that all coverage under this Plan is immediately canceled if (1) any Participant remains in the employ of an Employer that ceases Contributions to the Plan due to a cancellation of a Collective Bargaining Agreement or, (2) the Participant becomes employed by an electrical contracting industry Employer who does not contribute to this or some other IBEW Trust Fund.

4.13 Cancellation of Eligibility and Termination of the Hours Bank Reserve (Trust Agreement Non-Compliance and Contribution Reporting Requirements)

A Participant's eligibility and Hours Bank Reserve under this Plan will be canceled and he will not be entitled to further coverage under this Plan in the event that:

- A. The Participant continues to be employed by an Employer who ceases Contributions to this Plan pursuant to the termination of such Employer's Collective Bargaining Agreement; or
- B. The Participant becomes employed in Non-Covered Electrical Employment as defined in Section 1.16 of the Southern California IBEW-NECA Pension Plan, or if the Participant becomes employed by an employer in the same industry as any Employer that contributes to this Plan and the Participant's employer is not a contributing Employer to this Plan or any IBEW-sponsored trust fund.

4.14 Financing of the Plan

For working Participants, your benefits are paid from Contributions made by Employers pursuant to a Collective Bargaining Agreement. Under certain circumstances, your health care coverage may continue by making a self-payment (COBRA). See Article 17.1: COBRA on page 70 for more information.

Article 5: Choosing Between the HMO Plans and the PPO Plan

5.1 Choosing a Medical Plan That Best Suits Your Needs

There are two ways to find out if you live or work within either the UnitedHealthcare or Kaiser service area. For UnitedHealthcare you can either call Member Services at (800) 624-8822, or you can log on to the UnitedHealthcare website at www.uhcwest.com. For Kaiser, you can either call Member Services at (800) 464-4000, or you can log on to the Kaiser website at www.kaiserpermanente.org.

As a Participant in the Southern California IBEW-NECA Health Trust Fund, you may choose to enroll in either of the two Health Maintenance Organizations (HMOs) or in the Anthem Blue Cross PPO Plan. The HMO plans are Kaiser and UnitedHealthcare. As explained in Article 5.3: Rolling 12-Month Open Enrollment Procedure, you are allowed to change your choice of Plans after 12 months of continuous coverage.

This section is intended to help you become acquainted and familiar with the medical Plans available to you. A summary comparison of the two HMO plans and the Anthem Blue Cross PPO Plan appears at the end of this section, which provides greater detail regarding your benefits. For detailed and specific information about the benefits, exclusions and limitations of either of the HMO plans (Kaiser and UnitedHealthcare) or Anthem Blue Cross PPO Plan, please refer to the specific Evidence of Coverage document provided by either of the respective HMO plans or the Anthem Blue Cross PPO. Copies of Anthem Blue Cross', Kaiser's and UnitedHealthcare's Evidence of Coverage documents are available from the Administrative Office at no charge, or on the Trust Fund website at www.scibew-neca.org.

A. HMO Medical Plans – Kaiser and UnitedHealthcare

A Health Maintenance Organization consists of a network of health care providers and facilities. In the case of Kaiser, the physicians are employees of Kaiser and Kaiser typically owns the facilities. In the case of UnitedHealthcare, the physicians are independent practitioners who contract with UnitedHealthcare to provide medical services to eligible participants. UnitedHealthcare also contracts with hospitals and other facilities to provide services to eligible participants. Each HMO provides an Evidence of Coverage document, which explains in detail the services and benefits provided, as well as the limitations and exclusions of their respective plans.

The HMO you select (Kaiser or UnitedHealthcare) will provide you with an Evidence of Coverage document and other descriptive literature after you enroll, including an identification card. The medical facilities you must use are listed in the HMO packet you will receive. Importantly, you must use the physicians, hospitals and other medical providers associated with the HMO you select.

In order to enroll in an HMO, you must live or work within that HMO's service area. For Kaiser, the ZIP code of your home or principal place of work must be within Kaiser's service area which is defined by Kaiser's ZIP code listing. For UnitedHealthcare, you must live or work within a 30-mile radius of the Medical Group to which your selected primary care physician belongs.

Under the HMO Plans, covered services are generally provided without charge, or for a fixed co-payment.

The following sections provide you with general information for each of the two HMO's under contract with the Trust Fund. However, this information is only a summary, included here for easy reference. For complete information on either of the HMO plans, you should contact the HMO directly or the Administrative Office and request that they send you the HMO's Evidence of Coverage document and other descriptive literature for the HMO in which you are interested or enrolled. Copies of these documents are also available on www.scibew-neca.org.

B. Alternate Kaiser Plan–Sound Unit 45% and 50% Apprentices Only

The Board of Trustees recognizes that certain Sound Unit Apprentices (45% and 50%) receive contributions to the Plan at a substantially reduced contribution rate than that provided for other classifications of participants in the Plan, resulting in a significant pro-ration of those contributions which effectively prohibited the apprentice from every gaining eligibility.

A separate set of benefits are provided exclusively through Kaiser for the Sound Unit 45% and 50% apprentices only. Refer to Article 6.2: 45% and 50% Sound Apprentice – Kaiser Permanente on page 34 for more information. None of the other benefits described in this Active SPD are available to eligible Sound Unit 45% and 50% Apprentices and their dependents. However, the non-benefit provisions of this Plan, such as definitions, COBRA rights and appeal rights do apply to the 45% and 50% Sound Unit Apprentices.

Upon graduation to a 55% Sound Unit Apprentice level or higher, the hours remaining in the Hours Bank Reserve for the Alternate Kaiser Plan benefit will be transferred to the Active Hours Bank Reserve. The Participant will be transferred to the Active Kaiser HMO Plan of benefits and will remain enrolled in that plan for a minimum of 12 months and the participant will receive documentation from the Administrative Office regarding the additional benefits available at the time of transfer to the Active Kaiser HMO Plan.

Eligibility for coverage for Active Employees is based on your working a certain minimum number of hours as explained below with one or more Employers who actually make Contributions to the Fund on your hours of employment.

Even if an Employee's Hours Bank Reserve contains sufficient hours for initial eligibility, the only benefit an employee will have until he or she completes an enrollment form for the Alternate Kaiser Plan will be life insurance. Even if the employee fails to return the enrollment forms to the Administrative Office in a timely fashion, the employee's Hours Bank Reserve will be charged as if the employee has completed all the steps required for enrollment in the benefits offered by the Plan. However, the employee will have no actual coverage (except for life insurance) until the employee has completed all the steps required for enrollment in benefits offered by the Plan. The employee's failure to take appropriate action in enrolling for benefits will cause a reduction in the employee's Hours Bank Reserve without providing the employee with benefits or coverage, which would exist if the employee enrolled in the benefit available to him or her on a timely basis.

C. Anthem Blue Cross PPO Plan

The Anthem Blue Cross PPO Plan provides you with freedom of choice in selecting a physician, hospital or other medical provider. However, **in order to maximize benefits under the PPO plan, you should use doctors and hospitals which are part of the Anthem Blue Cross Prudent Buyer PPO network**, called "Participating Providers." When you use health care providers that are not in the Anthem Blue Cross PPO network, you may incur substantial out-of-pocket costs which are your financial responsibility.

This section provides you with general information for the Anthem Blue Cross PPO plan under contract with the Trust Fund. However, this information is only a summary, included here for easy reference. For complete information on the Anthem Blue Cross PPO plan, you should contact Anthem Blue Cross directly or the Administrative Office and request that they send you the Anthem Blue Cross PPO's Evidence of Coverage document and other descriptive literature for the PPO in which you are interested or enrolled.

Anthem Blue Cross will provide you with an Evidence of Coverage document. You should carefully review the benefits of the Anthem Blue Cross PPO plan to make certain it fits your needs and that you understand what your financial obligation (out-of-pocket costs) under this Trust Fund will be. By learning and applying a few basics, you may be able to reduce your out-of-pocket costs substantially.

When you use Anthem Blue Cross Participating Prudent Buyer physicians and hospitals, you receive greater benefits than if you were to go to a physician or hospital who is not an Anthem Blue Cross Prudent Buyer Participating provider. The difference in benefits between using a Participating Anthem Blue Cross Prudent Buyer provider and non-participating provider can be substantial, which affects your out-of-pocket costs.

The PPO providers under contract with the Anthem Blue Cross Prudent Buyer Plan agree to provide services at a reduced fee, and the savings are passed along to you in the form of a higher coinsurance, or less out-of-pocket cost to you. When you use a participating Prudent Buyer physician (In-Network), the coinsurance factor is 90% of a reduced pre-negotiated rate. If you use a non-participating provider (Out-of-Network), the coinsurance factor is reduced to 80% of the amount Anthem Blue Cross determines to be the reasonable and customary fee for the services provided. In this situation, you will be financially responsible for the 20% of the allowed amount that Anthem Blue Cross does not reimburse as well as the difference between what the physician charges and what Anthem Blue Cross allows as an eligible medical expense.

IMPORTANT: Anthem Blue Cross's reimbursement for out-of-network providers is based on 80% of covered charges and not 80% of the physician's bill for the services you receive. For example, if Anthem Blue Cross determines that a non-PPO physician charges a greater amount than what Anthem Blue Cross determines are the covered charges for the care provided (e.g. charges which are usual and customary and for medically necessary services), Anthem Blue Cross will reimburse 80% of the covered charges, which may be equivalent to only 60% or 70% of the provider's bill, instead of 80%.

Under the Anthem Blue Cross PPO Plan, you are responsible for the difference between what Anthem Blue Cross pays and what the provider charges.

A Prudent Buyer Plan directory is available for each of seven areas within the state of California. For example, there are separate directories for each of the following areas: Los Angeles County, Orange County and Inland Empire, Tri-Counties (San Luis Obispo/Santa Barbara/Ventura), and Bay Area Counties. You can find Prudent Buyer participating providers throughout the state of California.

Recognizing that there are sometimes changes between printings of the Summary Plan Description and other Plan documents, it is your responsibility to verify current Prudent Buyer status before you obtain services. **Remember to ask your doctor if he is an Anthem Blue Cross Prudent Buyer Participating Provider.** You can also phone the Administrative Office for assistance in identifying or locating a Prudent Buyer doctor, hospital, or other health care provider.

Anthem Blue Cross will supply you with an identification card, which identifies you as being eligible to use the Prudent Buyer Plan network of Participating Providers. Of course, to be eligible for Plan benefits you must work the required hours and be eligible for benefits as explained in Article 4: Eligibility and General Plan Provisions.

5.2 Enrollment Procedures

When you first become eligible for benefits (as explained in Article 4.1: Eligibility: When Coverage Begins) you will be allowed to choose the medical and dental plans by completing forms provided by the Trust Fund and filing them with the Administrative Office. You and your dependents must be enrolled in the same medical and dental plans; your spouse cannot enroll in an HMO plan if you are enrolled in the PPO plan.

If you do not select a medical and/or dental plan, you will not have coverage until you have selected a medical and/or dental plan. The only benefit a Participant will have until he or she completes an enrollment form for one of the medical options and one of the dental options will be Life and AD&D insurance. If you fail to enroll in a plan, the Administrative Office will provide you with written notification of the plans in which you failed to enroll. If you supply the proper enrollment materials for a medical plan option, but do not supply the proper enrollment materials for the dental plan, you will be promptly enrolled in the medical plan by the Administrative Office.

You may enroll in an HMO Plan only if you live within the HMO's service area which is a geographical jurisdiction defined by the HMO you select. For UnitedHealthcare, you must live or work within a 30-mile radius of a UnitedHealthcare participating provider (physician/medical group). For Kaiser, you must live or have your principal place of work within the Kaiser service area, which is defined by Kaiser according to a listing of ZIP codes.

5.3 Rolling 12-Month Open Enrollment Procedure

Once you are enrolled in a medical or dental plan you must remain enrolled in that plan for 12 consecutive months. After those 12 months, you may change your enrollment to an alternative plan that is then being offered by the Trust Fund. Example: Bob enrolls in the Anthem Blue Cross PPO Plan in February of 2017. Bob may first switch to an available HMO Plan for February 2018 coverage and may switch to any available medical plan option for any month after February 2019. To switch coverage Bob must request a change of coverage form from the Administrative Office, complete the form and return it to the Administrative Office by the 15th day of the month preceding the month he wants the change in coverage to begin. If Bob files a change form with the Administrative Office by March 15, 2018, his HMO coverage shall be effective April 1, 2018.

The Trustees have adopted two (2) exceptions to the requirement that you remain within a particular plan for a minimum of 12 months prior to switching to another plan.

First, if your physician, medical group or hospital discontinues participation in the HMO or PPO program in which you are enrolled, you may change your enrollment by submitting a change form to the Administrative Offices. This same exception is applicable to the Dental Plan. The Administrative Office will send you a change form upon request.

Second, if you are enrolled in an HMO Plan and move outside of the HMO's service area, you may change your enrollment by submitting a change form to the Administrative Office. The Administrative Office will send you a change form upon request.

Please refer to Article 5.1.2: Alternate Kaiser Plan–Sound Unit 45% and 50% Apprentices Only for information on special eligibility rules for Sound Unit 45% and 50% Apprentices.

5.4 Exception to the Rolling 12-Month Open Enrollment for UnitedHealthcare

UnitedHealthcare has contracts with certain designated medical groups that will only allow new participant enrollment on an annual basis. At the present time, the following medical groups fall into this category:

- UCLA
- Loma Linda
- Cedars-Sinai

UCLA, Loma Linda and Cedars-Sinai will only accept new participants who will be effective January 1st of each year. If you want to enroll in one of these medical groups, you should contact the Trust Fund Administrative Office during the month of October for a change date to be effective January 1st.

The list is subject to change and you may contact the Administrative Office for up to date information at any time.

If you are enrolled in one of the above listed medical groups, and wish to change to another medical group or to another Plan offered, you may do so only under the terms of the Rolling 12-Month Open Enrollment Procedure described above.

If you have any questions regarding this procedural change, please contact the Administrative Office at (323) 221-5861 or the nationwide toll free-number (800) 824-6935. Please state that you are calling about the open enrollment change so that your call can be directed promptly. Office hours are 8:30 a.m. – 5:30 p.m., Monday-Friday.

Article 6: Comparison of Anthem Blue Cross PPO, Kaiser HMO and UnitedHealthcare HMO Medical Plans

The benefits chart titled “Medical Benefits Comparison: Anthem Blue Cross, Kaiser and UnitedHealthcare” is only a representative summary of the coverage and benefits available under the two HMO plans, Kaiser and UnitedHealthcare and the Anthem Blue Cross PPO plan. It does not fully describe your coverage and benefits under either the PPO or the HMO plans. For details on your coverage and benefits, please refer to the respective PPO or HMO’s Evidence of Coverage document. The Evidence of Coverage document is the legal document that describes the benefits, limitations, exclusions, and other coverage provisions provided by either the PPO or HMO to its members. The current Evidence of Coverage document is available directly from the HMO (Kaiser or UnitedHealthcare) or the PPO (Anthem Blue Cross) as well as from the Administrative Office (or on www.scibew-neca.org) upon request.

An HMO physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat your medical condition. The services and supplies must be provided, prescribed, authorized, or directed by an HMO physician. You must receive the services and supplies at an HMO facility inside the HMO’s service area, except where specifically noted to the contrary in the respective HMO’s Evidence of Coverage document.

For details on the benefit and claim review and adjudication procedures for either the HMO or the PPO plan, please refer to the respective HMO or PPO’s Evidence of Coverage document or contact the HMO or PPO’s Membership Services Department at:

Anthem Blue Cross: (800) 543-3037

Kaiser: (800) 464-4000

UnitedHealthcare: (800) 624-8822

6.1 Medical Benefits Comparison: Anthem Blue Cross, Kaiser and UnitedHealthcare

Comparison of Medical Plan Offerings				
<p>This is only a summary of the benefits available to you under the Anthem Blue Cross PPO Plan and the Kaiser and UnitedHealthcare HMO Plans. For a complete description of the respective PPO or HMO's benefits, please refer to the carrier's EVIDENCE OF COVERAGE AND DISCLOSURE DOCUMENT. The EVIDENCE OF COVERAGE AND DISCLOSURE DOCUMENT is the legal document that describes the benefits, exclusions and limitations and other coverage provisions including claims appeals, claims review and adjudication procedures. Additionally, the Summary of Benefits and Coverage (SBC) are available, routinely distributed and appear on the Trust Funds' website at www.scibew-neca.org.</p>				
Vendor	Anthem Blue Cross PPO		Kaiser HMO	UnitedHealthcare
	In Network	Out-of-Network	In Network Only	In Network Only
Member Customer Service Number	(800) 543-3037		(800) 464-4000	(800) 624-8822
Website	www.bluecrossca.com		www.members.kp.org	www.uhcwest.com
General Features				
Calendar Year Deductible	\$200 per individual, \$600 per Family		None	None
Maximum Benefits	Unlimited		Unlimited	Unlimited
Annual Co-payment Maximum	\$1,000 per individual, \$2,000 per family		\$1500 per Individual, \$3,000 per family	\$1000 per Individual. \$3,000 per family
Hospital Benefits	10% co-payment. Hospital Pre-Certification Required.	20% co-payment. Additional \$200 deductible for non-Anthem Blue Cross PPO Hospital or Residential Treatment Center and \$500 no- preauthorization penalty (waived for emergency services) Hospital Precertification Required. ²	No Charge	No Charge
Emergency Services	10% co-payment ¹	10% co-payment. ²	\$5 co-payment. Co-payment waived if admitted.	\$50 co-payment. Co-payment waived if admitted.
Preexisting Conditions	Not Applicable. All conditions are covered provided they are a covered benefit.			
Benefits Available While Hospitalized as an Inpatient				
Alcohol, Drug or Other Substance Abuse Detoxification	10% co-payment ¹	20% co-payment ²	No Charge	No Charge
Mental Health Services (As required by law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance (SED).	10% co-payment ¹	20% co-payment ²	No Charge	No Charge
Newborn Care	10% co-payment ¹	20% co-payment ²	No Charge	No Charge
Physician Care	10% co-payment ¹	20% co-payment ²	No Charge	No Charge
Reconstructive Surgery	10% co-payment ¹	20% co-payment ²	No Charge	No Charge

Comparison of Medical Plan Offerings

This is only a summary of the benefits available to you under the Anthem Blue Cross PPO Plan and the Kaiser and UnitedHealthcare HMO Plans. For a complete description of the respective PPO or HMO's benefits, please refer to the carrier's EVIDENCE OF COVERAGE AND DISCLOSURE DOCUMENT. The EVIDENCE OF COVERAGE AND DISCLOSURE DOCUMENT is the legal document that describes the benefits, exclusions and limitations and other coverage provisions including claims appeals, claims review and adjudication procedures. Additionally, the Summary of Benefits and Coverage (SBC) are available, routinely distributed and appear on the Trust Funds' website at www.scibew-neca.org.

Vendor	Anthem Blue Cross PPO		Kaiser HMO	UnitedHealthcare
	In Network	Out-of-Network	In Network Only	In Network Only
Rehabilitative Care (including physical, occupational and speech therapy)	10% co-payment. Must obtain prior approval. ¹	20% co-payment. Up to \$35 max benefit per visit. Must obtain prior approval. ²	No Charge	No Charge
Skilled Nursing	10% co-payment.	20% co-payment. ²	No Charge	No Charge
Voluntary Termination of Pregnancy (Medical, Medication and surgical)	10% co-payment.	20% co-payment. ²	\$5 Co-payment	\$75 co-payment
Benefits Available on an Outpatient Basis				
Ambulance	10% co-payment ¹	10% co-payment ²	No Charge	No Charge
Durable Medical Equipment	10% co-payment.	20% co-payment. ²	No Charge	No Charge
Durable Medical Equipment for the Treatment of Pediatric Asthma (includes nebulizer, peak flow meters, face masks and tubing for Medically Necessary Treatment of Pediatric Asthma of dependent children under the age of 19)	10% co-payment.	20% co-payment. ²	No Charge	No Charge
Immunizations (For Children Under two (2) years of age, refer to well-baby care)	No Charge	20% co-payment ²	\$5 Office Visit Co-payment	No Charge
Laboratory Services (When available through or authorized by PCP)	10% co-payment.	20% co-payment. ²	No Charge	No Charge
Mental Health Services (As required by law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance (SED).	10% co-payment ¹	20% co-payment ²	\$5 Office Visit Co-payment	\$5 Office Visit Co-payment
Oral Surgery Services	10% co-payment ¹	10% co-payment ²	No Charge	No Charge
Outpatient Medical Rehabilitation Therapy at Participating Free Standing or Outpatient Surgery Facility	10% co-payment ¹	20% co-payment ²	\$5 Office Visit Co-payment	\$5 Office Visit Co-payment
Outpatient Surgery at Participating Free Standing or Outpatient Surgery Facility	10% co-payment.	20% co-payment. ²	No Charge	No Charge

Comparison of Medical Plan Offerings

This is only a summary of the benefits available to you under the Anthem Blue Cross PPO Plan and the Kaiser and UnitedHealthcare HMO Plans. For a complete description of the respective PPO or HMO's benefits, please refer to the carrier's EVIDENCE OF COVERAGE AND DISCLOSURE DOCUMENT. The EVIDENCE OF COVERAGE AND DISCLOSURE DOCUMENT is the legal document that describes the benefits, exclusions and limitations and other coverage provisions including claims appeals, claims review and adjudication procedures. Additionally, the Summary of Benefits and Coverage (SBC) are available, routinely distributed and appear on the Trust Funds' website at www.scibew-neca.org.

Vendor	Anthem Blue Cross PPO		Kaiser HMO	UnitedHealthcare
	In Network	Out-of-Network	In Network Only	In Network Only
Physician Office Visits (Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices (ACIP) and U.S. Preventive Services Task Force and authorized through PCP for children).	10% co-payment ¹	20% co-payment ²	\$5 Office Visit Co-payment	\$5 Office Visit Co-payment
Well-Baby Care (Preventive health service, including immunizations as recommended by the American Academy of Pediatrics (AA), Advisory Committee on Immunization Practices (ACIP) and U.S. Preventive Care Task Force and authorized through PCP for children).	0% co-payment ¹	20% co-payment ²	No Charge	No Charge
Well-Woman Care (includes PAP smear (By PCP or an OB/GYN in PMG and a referral by the PMG for screening mammography as recommended by the U.S. Preventive Services Task Force).	0% co-payment ¹	20% co-payment ²	No Charge	No Charge

1 Subject to the annual deductible.

2 Subject to the annual deductible and balance billing.

6.2 45% and 50% Sound Apprentice – Kaiser Permanente

Southern California IBEW-NECA Health Trust Fund

CID# 101155 Apprentices

Principal Benefits for Kaiser Permanente Traditional Plan

The Services described in this section are covered only if all of the following conditions are satisfied:

1. The Services are Medically Necessary
2. The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the Evidence of Coverage (EOC) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

A. Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Co-payments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)\$1,500 per calendar year

For any one Member in a Family of two or more Members.....\$1,500 per calendar year

For an entire Family of two or more Members.....\$3,000 per calendar year

B. Deductible or Lifetime Maximum

None

C. Professional Services (Plan Provider office visits)

	<u>You Pay</u>
Most primary and specialty care consultations, exams, and treatment	\$25 per visit
Routine physical maintenance exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge

Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	\$25 per visit
Physical, occupational, and speech therapy	\$25 per visit

D. Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures.....	\$250 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine).....	No charge
Most X-rays and laboratory tests	No charge
Health education	
Covered individual health education counseling	No charge
Covered health education programs.....	No charge

E. Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	\$500 per admission
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F. Emergency Health Coverage

You Pay

Emergency Department visits	\$100 per visit
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Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered services (see "Hospitalization Services" for inpatient Cost Sharing).

G. Ambulance Services

You Pay

Ambulance Services.....	\$50 per trip
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H. Prescription Drug Coverage

The outpatient prescription drugs listed in the EOC in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service (most outpatient prescription drugs are not covered)

You Pay

\$15 for up to a 30-day supply,
\$30 for a 31- to 60-day supply,
\$45 for a 61- to 100-day supply
for base drugs only

I. Durable Medical Equipment

Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines

You Pay

No charge

J. Mental Health Services

Inpatient psychiatric hospitalization \$500 per admission
Individual outpatient mental health evaluation and treatment \$25 per visit
Group outpatient mental health treatment..... \$12 per visit

You Pay

K. Chemical Dependency Services

Inpatient detoxification \$500 per admission
Individual outpatient chemical dependency evaluation and treatment \$25 per visit
Group outpatient chemical dependency treatment..... \$5 per visit

You Pay

L. Home Health Services

Home health care (up to 100 visits per calendar year)..... No charge

You Pay

M. Other

You Pay

Skilled nursing facility care (up to 100 days per benefit period)..... No charge

Covered external prosthetic devices, orthotic devices,
and ostomy and urological supplies..... No charge

Hospice care..... No charge

NOTE:

The benefits chart for 45% and 50% Sound Apprentices is only a representative summary of the coverage and benefits available under the Alternate Kaiser Plan for the Sound Unit 45%-50% Apprentices. It does not fully describe the coverage and benefits.

For details on your coverage and benefits, please refer to the Evidence of Coverage document. The Evidence of Coverage document is the legal document that describes the benefits, limitations, exclusions, and other coverage provisions provided by the HMO to its members. The current Evidence of Coverage document is available directly from Kaiser, as well as from the Administrative Office, upon request.

A Kaiser physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat a medical condition. The services and supplies must be provided, prescribed, authorized, or directed by a Kaiser physician. You must receive the services and supplies at a Kaiser facility, except where specifically noted to the contrary in the respective HMO's Evidence of Coverage document.

For details on the benefit and claim review and adjudication procedures, please refer to the Evidence of Coverage document or contact Kaiser's Membership Services Department at (800) 464-4000.

Article 7: Health Reimbursement Arrangement

If required under the terms of a Collective Bargaining Agreement or certain other agreements, an Employer may make pre-tax contributions on behalf of a Participant to this Plan for funding a Health Reimbursement Arrangement (“HRA”). Amounts contributed to an HRA Account, if any, may be used to reimburse a Participant tax-free for certain medical expenses which are not covered by this Plan or any other health plan. If a Participant’s spouse and/or children are eligible under the terms of this Plan, their reimbursable medical expenses qualify for tax-free reimbursement from the HRA Account. All HRA contributions are Fund assets. Participants are not vested in any contributions made on their behalf, and an HRA Account may only be used in accordance with the terms of the Plan.

Claims for HRA qualified reimbursable expenses may be submitted to the Southern California IBEW-NECA Health Trust Fund in care of the Third Party Administrator on or after September 1, 2017.

7.1 Active Participant Eligibility

If an Employer makes an HRA contribution to the Plan on behalf of a Participant, the Participant is entitled to use these contributions, subject to the terms of the Plan once he/she becomes eligible to participate in the Plan. The Participant’s HRA benefit is called an HRA Account. An HRA Account may be used to reimburse eligible expenses incurred by the Participant, his/her eligible spouse and his/her eligible dependents as defined under the Plan.

7.2 Loss of Eligibility

Once a Participant and/or eligible dependent ceases to be eligible under the Active Health Plan, no subsequently incurred expenses may be reimbursed until you regain eligibility. However, you may use funds in your HRA account to pay COBRA premiums and retiree self-payments. Spouses ceasing eligibility due to divorce or dependents due to age lose all rights to HRA reimbursement and may not use any HRA account balance of a Participant for COBRA premiums because the HRA account is always held by the Participant. A deceased Participant’s rights pass to eligible dependents at the time of death (See Article 7.5: COBRA Continuation Coverage).

7.3 Benefit Amount

The amount of the HRA benefit in any Calendar Year is determined by the number of hours the Participant works in Covered Employment for which contributions are actually received, multiplied by the rate set forth in the Collective Bargaining Agreement (CBA) or other agreement. If the HRA Account is not used in any one Calendar Year, it may be carried over year-to-year until depleted. It is expected that this benefit will be provided as long as the CBA or other agreement provides for a contribution for such a benefit and, once an HRA Account is established, as long as a Participant has a balance remaining in his/her HRA Account (subject to the forfeiture rules listed below). The Trustees, however, retain the right to change the rules pertaining to this benefit or terminate this benefit as they deem appropriate.

7.4 Forfeitures

- A. The HRA Account of a Participant shall be immediately and permanently forfeited if any of the following apply to the Employee:
 - 1. The Participant engages in Non-Covered Electrical Employment by being employed in any capacity and for any duration by a contractor in the Electrical Industry who is not signatory to the CBA of an IBEW Local having jurisdiction of the work, or
 - 2. The Participant is an owner of a company in the Electrical Industry which is not signatory to a CBA of an IBEW Local having jurisdiction of the work.
- B. The HRA Account of a deceased Participant shall be forfeited if the Participant dies without any dependents eligible for any form of extended benefits under this Plan.
- C. If a Participant or the surviving dependents of a deceased Participant have had no coverage whatsoever under the Southern California IBEW-NECA Active or Retiree Plan for a period of 60 or more months, the HRA Account balance shall be reduced to zero.

7.5 COBRA Continuation Coverage

If a Participant loses coverage under the Active Plan for any reason other than Non-Covered Electrical Employment the Participant may use his/her account to pay the cost of his/her COBRA coverage under the Active Plan and that of his/her eligible dependents.

If a Participant eligible under the Active Plan dies, his/her eligible dependents may use the deceased Participant's HRA Account to pay the cost of their COBRA coverage under the Active Plan. A surviving Spouse shall always have primary control over the HRA Account. If there is no Surviving Spouse, eligible dependents shall have pro rata rights to the HRA Account for COBRA purposes and nothing prevents a surviving eligible dependent from waiving their interest in favor of other surviving eligible dependents for purposes of COBRA continuation coverage under the Active Plan.

7.6 Southern California IBEW-NECA Retiree Health Plan Self Payments

Some Active Participants under the Plan may be eligible upon retirement to enroll in the Southern California IBEW-NECA Retiree Health Plan. That Program requires Retiree self-payments for ongoing coverage. A Participant enrolling in the Retiree Health Plan may utilize his/her HRA Account for required Retiree Health Plan self-payments.

In the event of the death of a Retiree Health Plan Participant, the Participant's Surviving Spouse may utilize the HRA account to make self-payments under the Retiree Health Plan and pay for supplemental insurance such as dental/vision coverage, but not to pay for a separate health insurance plan. While eligible under the Retiree Health Plan, the Surviving Spouse may also use the HRA account to pay for eligible expenses.

7.7 Payment of Large Claims

If a Participant files a claim for the HRA Account but there are insufficient funds in the Account to pay the entire claim, the Plan will pay only the amount in the HRA Account. Once additional contributions have been credited to the HRA Account, the Participant may re-file the claim for additional reimbursement.

7.8 Reimbursable Expenses

An HRA Account may be used to reimburse eligible health care expenses incurred by the Participant or his/her spouse or his/her eligible dependents which would otherwise be only partially covered or excluded from coverage by the Plan and any other health plan.

Reimbursable expenses are those that constitute medical care under Section 213 of the Internal Revenue Code. An HRA Account may be used to reimburse the Participant for Plan deductibles, co-payments, and other non-covered expenses for medical, prescription drug, dental, vision and psychiatric services. An HRA Account may also be used to pay for self-pay premiums, COBRA premiums, other medical plan coverage, Medicare supplemental coverage, and long-term care insurance premiums.

To be eligible for reimbursement, the Participant must be eligible for Health Plan coverage under the rules of the Plan, and the expenses must be incurred on or after September 1, 2017.

Examples of eligible expenses are as follows:

1. Co-payments, co-insurance and deductibles
2. Acupuncture
3. Chiropractic visits
4. Crutches
5. Dental expenses
6. Durable medical equipment
7. Expenses that exceed medical, hospital, dental or vision plan limits
8. Eye exams, glasses and contact lenses
9. Hearing aids
10. Orthodontia
11. Orthotics
12. Physical therapy
13. Prescription drugs and non-prescription drugs prescribed by a physician

14. Physiotherapy
15. Transportation expenses related to medical care
16. Well baby and well child care

Examples of ineligible expenses are as follows:

1. Cosmetic services
2. Expenses claimed on an income tax return
3. Expenses that are actually reimbursed or subject to reimbursement by any other source such as an insurance policy, an employer, Medicare or any other government health program
4. Fees for exercise or health clubs, unless medically necessary
5. Hair transplants
6. Weight loss programs that are not medically necessary
7. Medical expenses that are experimental or not medically necessary

7.9 Claims Procedures

No reimbursement of submitted claims will be made from a Participant's HRA Account unless aggregate eligible claims submitted provide for reimbursement of at least \$25.00. Individual claims may be aggregated to meet the \$25.00 minimum. An HRA Reimbursement Claim Form must be submitted to the Third Party Administrator selected by the Trust Fund that not only processes the claims received but also handles all non-eligibility based appeals related to specific claims. No claims are ever to be submitted to the Administrative Office other than disputes as to eligibility. Claim forms will be available from the Administrative Office or the Trust Funds website at www.scibew-neca.org and will require the Participant's certification that the expenses were not reimbursed, and are not reimbursable, by this or any other plan. Along with the HRA Reimbursement Claim Form, supporting documentation must be provided describing the expenses and proving that the Participant (or eligible spouse or other eligible dependents) paid the expenses. Supporting documentation may include the following:

1. An itemized bill describing the services provided, the person to whom the services were provided, the date of service, and the charged amount.
2. An Explanation of Benefits (EOB)
3. A receipt showing proof of payment

7.10 Reciprocity

Contributions received for HRA Accounts are considered part of the overall hourly health and welfare contribution for purposes of reciprocity and will be reciprocated to a Home Fund whenever the total hourly contribution rate for health and welfare coverage is equal to or less than the individual's home hourly contribution rate. See Article 4.4 I.O. Health Reciprocal Agreement and Proration Under Certain Collective Bargaining Agreements on page 15 for a full description of transferring contributions to a Home Fund and for a description of the crediting of incoming reciprocal contributions. HRA accounts are credited with incoming reciprocity only when the incoming reciprocal transfer is at an hourly rate which exceeds the non-HRA rate of this Plan under the Inside Wireman Agreement.

Article 8: Mandatory Generic Prescription Drug Plan

If you are eligible for health benefits provided by the Southern California IBEW-NECA Health Trust Fund (Anthem Blue Cross PPO Plan, Kaiser HMO, or UnitedHealthcare HMO), then you and your eligible dependents are entitled to prescription drug benefits, as described herein.

The Mandatory Generic Prescription Drug Plan is designed to help you meet the cost of prescription drugs prescribed by your doctor, for you or your eligible dependents, for the treatment of illness or injury.

You must use a generic drug substitute whenever it is available. If you or your doctor requests a brand-name drug instead of a generic equivalent, you will be charged the difference in cost between the brand-name drug and the generic, in addition to the co-payment applicable to the quantity and type of drug prescribed. The co-payments, which vary depending on the type of drug prescribed and the quantity dispensed, are detailed in this Article.

To fill your prescription, you can use any of the following:

- Citizens Rx Walk-In Pharmacy Plan (contracted network of pharmacies)
- Citizens Rx Mail Service Pharmacy Plan
- The participant must contact the Administrative Office to request a direct member reimbursement form for purchasing prescriptions out of network.

Each Plan is described in greater detail in the following sections.

8.1 Walk-In Pharmacy Plan (Citizens Rx)

Generic Drug: \$0 Co-payment per Prescription for up to a 30-day supply

Brand-Name Drug: \$10 Co-payment per Prescription for up to a 30-day supply

Maintenance Medications as described below:

Generic Drug: \$0 Co-payment per Prescription for up to a 100-day supply

Brand-Name Drug: \$20 Co-payment per Prescription for up to a 100-day supply

To obtain a prescription as outlined in this section for a fixed co-payment, you must use a network pharmacy. The pharmacy network is extensive and includes most major chains and many independent pharmacies. A listing of the California network pharmacy chains is included at the end of this section. An up to date listing of nationwide pharmacies can also be found online at www.citizensrx.com or you can call Citizens Rx Customer Service toll free line, (877) 532-7912 to find a pharmacy near you.

You simply pay directly to the pharmacy a co-payment for each prescription. The Plan allows up to a 30-day supply or up to a 100-day supply if a maintenance drug is prescribed by your doctor.

As a cost-containment feature, the Plan requires that you use a generic drug substitute when it is available.

It is important to note, however, that if the prescription calls for a brand name, the pharmacist will dispense the generic drug whenever a generic equivalent is in stock and may legally be substituted for the prescribed brand name.

If you or your doctor requests a brand-name drug instead of a generic equivalent, you will be charged the difference in cost between the brand-name drug and the generic, in addition to the co-payment applicable to the quantity and type of drug prescribed. The co-payments, which vary depending on the type of drug prescribed and the quantity dispensed, as set forth above.

8.2 Mail Service Pharmacy Plan (Citizens Rx)

(For Maintenance Medications Only)

Generic Drug: \$0 Co-payment per Prescription for up to a 100-day supply

Brand-Name Drug: \$20 Co-payment per Prescription for up to a 100-day supply

A Mail Service Prescription Drug Plan is available for maintenance medications. Maintenance medications are prescribed for such conditions as high blood pressure, diabetes, heart disease, ulcers, arthritis and other chronic conditions. You may obtain up to a 100-day supply of a maintenance medication drug for your \$0 Generic or \$20 Brand-Name co-payment (when there is no generic equivalent for the brand-name drug). Maintenance prescription drugs will be mailed directly to your home by Citizens Rx. Your prescription should arrive within seven (7) working days after your order is received at the Citizens Rx Mail Service Pharmacy. Citizens Rx pays all mailing expense for standard deliveries.

Your co-payment can be paid by check, money order, or credit card. Your prescription can be sent in a pre-printed envelope supplied by Citizens Rx and your medication will be delivered to your home within seven (7) working days after your order is received. You can order refills over the Internet at www.citizensrx.com or by phone by calling (877) 532-7912. You may also call this toll-free number to ask any questions or raise any concerns you may have regarding your prescription.

8.3 Non-Participating Pharmacy Reimbursement Plan

Generic Drug: \$5 Co-payment per Prescription – for up to a 30-day supply

Brand-Name Drug: \$15 Co-payment per Prescription – for up to a 30-day supply

A. Limits on Drug Claim Reimbursement

You may go to any non-network pharmacy of your choice. Under this Plan, you must contact the Administrative Office to request a direct member reimbursement form for purchasing prescriptions from non-participating pharmacies. You will be reimbursed for the prescription

based on a limited formula, less a co-payment of \$5 for each generic drug prescribed or \$15 for each brand-name drug prescribed, up to a 30-day supply.

Under this Plan, you may be responsible for most of the drug cost, therefore you are encouraged to use the Citizens Rx Walk-In Pharmacy or Mail Service Prescription Drug Plan whenever possible. This Non-Participating Pharmacy Reimbursement Plan is intended for emergency purposes (for example traveling away from home) or other emergency situations.

B. How to File a Claim

Claim forms may be obtained from the Administrative Office. One portion of the claim form is to be completed by you, the other by the pharmacy. Claim forms must be filed within 15 months of the date of the drug charge to be eligible for reimbursement. Completed claim forms may be mailed to the following address:

Citizens Rx
1144 Lake Street - 4th Floor
Oak Park, IL 60301

C. Claim Payments

Claims will generally be processed within 30 days from the date the claim is received by Citizens Rx.

8.4 Covered Benefits

The Mandatory Generic Prescription Drug Plan covers the following services and materials:

1. Federal Legend Drugs: Any medicinal substance which bears the legend, "Caution: Federal law prohibits dispensing without a prescription."
2. State Restricted Drugs: Any medicinal substance, which may be dispensed by prescription only according to state law.
3. Federal legend Oral Contraceptives/Birth control pills
4. Contraceptive products, including, but not limited to Diaphragms, Cervical Caps, Depo-Provera Injection and Ortho-Evra Patches.
5. Inhaler extender devices and bags (Aerochamber™, Aerochamber™, w/ mask, Easivent™, Inspirsease™, EZ-Spacer™, Optichamber™, Optihaler™, Ellipse, etc.) are part of the pharmacy benefit.
6. Anaphylaxis prevention kits, including but not limited to Epi-Pen™/Epi-Pen Jr.™, Ana-Kits™, Ana-Kit Jr.™, Glucagon, Glucagon Emergency Kit, and Ana-Guard™.
7. Compounds with at least one federal legend or state restricted ingredient

8. Normal saline for inhalation and irrigation
9. Prescription prenatal vitamins
10. Injectables (see the Exclusions subsection below for exceptions)

The following non-prescription items are also covered when prescribed in writing by a physician and dispensed by a licensed pharmacist:

1. Insulin, insulin syringes and needles
2. Blood glucose test strips
3. Urine glucose test strips
4. Sterile lancets
5. Novolin Pen, Humulin Pen, Prefilled pens, Pen needles; cartridges

8.5 Limitations

The following items are a covered benefit subject to the limitations as stated below:

1. Drugs for sexual dysfunction for both males and females are limited to a maximum of eight (8) pills for a 30-day supply and the co-payment will be the same as any other drug.
2. Smoking deterrents when prescribed in writing, by a physician, subject to the following limitations: up to 90 days' supply per year; lifetime maximum benefit, 180 days' supply.

This limitation applies to smoking deterrents received from both retail and mail pharmacy outlets. It is recommended you discuss a treatment plan with your physician. There are many products to assist you in smoking Cessation. These include the following:

- a) Nicotine Patches
 - b) Nicotine Gum
 - c) Nicotine Nasal Spray (Rx Required)
 - d) Nicotine Inhalers (Rx Required)
 - e) Nicotine Lozenges
 - f) Zyban (Bupropion) (Rx Required)
3. Morning after pills and kits (*i.e.*, Preven, Plan B) - (limited to two (2) total per person per 365 days)

8.6 Exclusions

The following items are not covered:

1. If enrolled in an HMO (Kaiser or UnitedHealthcare), all injectables, except insulin, which are included as part of your medical benefit to be administered in a doctor's office, and are an exclusion, Citizens Rx, and out-of-network plans.
2. Drugs for which no charges are made, or which are provided under any Workers' Compensation or similar benefit or for which reimbursement is provided by any federal, state, or other governmental agency.
3. Medications available without a prescription (over-the-counter) or prescription medications for which there is a non-prescription equivalent available, even if ordered by a physician via a prescription, except as listed under Covered Drugs
4. Infertility drugs.
5. Anorexiant/appetite suppression weight loss drugs.
6. Medications to be taken or administered to the eligible member while he is a patient in a hospital, nursing home (skilled nursing care only), rest home, sanitarium, etc.
7. Medications used for cosmetic purposes (For example: Renova, Rogaine, Vaniqa, Penlac, Pigmenting and Depigmenting agents).
8. Medical devices, therapeutic devices or appliances including hypodermic needle syringes, (except insulin syringes) support garments and other non-medicinal substances (unless listed as covered).
9. Drugs or medicines purchased and received prior to the member's effective date or subsequent to the member's termination.
10. Drugs or medicines purchased or administered to the participant by a prescriber or prescriber's staff. For example, drugs administered, injected or dispensed by a physician. However, injectables obtained at a pharmacy shall be covered.
11. Medications prescribed for experimental or non-FDA approved indications unless prescribed in a manner consistent with a specific indication in Drug Information for the Health Care Professional, published by the United States Pharmacopoeial Convention, or in the American Hospital Formulary Services edition of Drug Information; medications limited to investigational use by law.
12. All homeopathic medications.
13. Unit dose drugs (unless only available as unit dose).
14. Vitamins (other than prescription prenatal vitamins).

15. Dental related products (prescription oral and topical fluoride, Peridex, Atridox, Periostat).
16. Drug claims submitted after 15 months of the date the drug was dispensed.
17. Biological sera.
18. Blood and Blood plasma.

8.7 Citizens Rx California Pharmacy Chains

The following is a list of Citizens Rx contracted California chains as of the date of printing of this Summary Plan Description:

- Albertsons
- Big "A" Drug Stores
- Costco
- CVS
- Gemmel Pharmacy
- Horton and Converse
- K-Mart
- Longs
- Pavilions Pharmacies
- Raley's Super Stores
- Ralphs
- Rite Aid
- Safeway
- Save Mart Supermarkets
- Sav-On Drugs
- Shopko Stores

- Target
- Vons/Pavilions Pharmacies
- Walgreens

Article 9: Dental Plans Available to You

You may choose one of the following:

- United Concordia Plan (PPO)
- CIGNA Dental Plan (DHMO)
- DeltaCare USA Dental Plan (DHMO)
- United Concordia Dental Plan (DHMO)

The Administrative Office offers four (4) dental plans from which to choose: a dental Preferred Provider Organization (PPO) plan and three (3) Dental Health Maintenance Organizations (DHMO) plans. The dental PPO plan is provided by United Concordia. The DHMO plans are CIGNA, DeltaCare USA (also known as Delta Dental), and United Concordia. We suggest that you carefully review all of the Plans, and discuss these different Plan options with your family members. A brief overview of the United Concordia PPO Plan and the DHMO plans (CIGNA, DeltaCare USA and United Concordia) appears on the following page. Please refer to your ***Evidence of Coverage*** document for a complete description of your dental benefits, including the exclusions and limitations.

To maximize benefits under the PPO plan, you should use dentists which are part of the United Concordia PPO network.

When you use United Concordia PPO participating dentists, you receive greater benefits than if you go to a dentist who is not a United Concordia PPO provider. The difference in benefits between using a participating United Concordia PPO provider can be substantial, which affects your out-of-pocket costs.

9.1 Comparison of Dental Benefits Available to You

This summary of the DHMOs' benefits, exclusions, limitations, and other provisions affecting dental benefits is not intended to take the place of the respective DHMO's Evidence of Coverage document or Schedule of Benefits. Please refer to your Evidence of Coverage and Disclosure Document for a complete description of your dental benefits, including the exclusions and limitations. In the event of any conflict between the information summarized in this section and the DHMO's Certificate of Insurance document or Schedule of Benefits, the DHMO's Certificate of Insurance document or Schedule of Benefits shall govern.

Dental Provider Name	United Concordia	Cigna	DeltaCare	United Concordia
Plan Type	PPO	DHMO	DHMO	DHMO
Member Customer Service	(800) 332-0366	(800) CIGNA-24	(800) 422-4234	(866) 357-3304
Website Address	unitedconcordia.com	cigna.com	deltadentalins.com	unitedconcordia.com
Claims Filing Address <i>Applies to PPO plan only</i>	P.O. Box 69421, Harrisburg, PA. 17106-9421			
Description	MEMBER CO-PAYMENT			
Network	In-Network/ Out-of-Network	In-Network Only	In-Network Only	In-Network Only
Annual deductible				
Per individual	\$0/\$25	N/A	N/A	N/A
Per family	\$0/\$75	N/A	N/A	N/A
Annual Maximum <i>Waived for diagnostic and preventive</i>				
Per individual	\$2,500/\$2,000	N/A	N/A	N/A
Per family	N/A	N/A	N/A	N/A
Diagnostic/Preventive <i>X-rays, exams, cleanings</i>	0%/0%, plus balance billing	\$0	\$0	\$0
Basic <i>Fillings, sealants, oral surgery, root canals</i>	5%/20% plus balance billing	\$0 - \$430	\$0 - \$220	\$0 (for white fillings)
Major <i>Crowns and casts, dentures, bridges and implants</i>	25%/50% plus balance billing Implants only: 25%/25% plus balance billing	\$12 - \$725	\$0 - \$195, implants not covered	\$0 (for metal crowns and bridges)
Orthodontics <i>Typical cost of completing a 24-month orthodontic treatment plan for permanent teeth for children, up to 19th birthday</i>	50%/50% plus balance billing, up to max payment of \$1,400	\$50 - 2,328	\$800 - \$1,150	\$1,500 - \$2,000, startup and retention charges not noted
Emergency Services <i>Emergency exam</i>	0%/0% plus balance billing	\$0-\$68	\$5	\$0

Article 10: Vision Benefits

10.1 Vision Service Plan (VSP) and Kaiser Vision Plan

If you are eligible for health benefits under the **UnitedHealthcare HMO Plan or the Anthem Blue Cross PPO Plan** provided by the Trust Fund, then you and your eligible dependents are entitled to vision benefits as described herein.

Participants and eligible dependents enrolled in the **Kaiser HMO Plan** are provided separate vision benefits through Kaiser and are not eligible for the Vision Service Plan coverage as described below, except that Kaiser HMO members are eligible for prescription safety glasses for employees only as explained herein.

A. Benefits

Vision Examination. A complete analysis of the eyes and related structures to determine the presence of vision problems, or other abnormalities.

Lenses. The VSP Providers will order the proper lenses (only if needed). The program provides the finest quality lenses fabricated to exacting standards. The doctor also verifies the accuracy of the finished lenses.

Frames. The Plan offers a wide selection of frames. However, if you select a frame that costs more than the amount allowed by the Plan, there will be an additional charge. If you order frames through a VSP doctor, you will receive a 20% reduction in the amount of the cost of the frames which exceeds VSP's allowance.

Contact Lenses. Contact lenses are in lieu of frames and lenses for your eligibility period.

Cosmetic contact lenses, when chosen by patients will have an allowance made toward their cost by VSP.

Prescription Safety Glasses. The plan covers prescription safety glasses for participants only.

Note: There is no coverage for Plano (non-prescription) safety glasses.

10.2 Co-Payments and Schedule of Benefits

Anthem Blue Cross and UnitedHealthcare Plan Participants				
Benefit	Frequency (Based on service year)	Co-payment	Coverage from a VSP doctor	Out-of-Network Reimbursement
Exam	12 months	\$5	Covered in full after the co-payment.	Up to \$45 allowance
Prescription Eyewear – If you choose contact lenses you will be eligible for frame 12 months from the date the contact lenses were obtained.				
Lenses	12 months	\$10 (lenses and/or frame)	Single vision, lined bifocal and lined trifocal lenses are covered in full after the co-payment.	Single vision up to \$45 allowance Lined bifocal up to \$65 allowance Lined trifocal up to \$85 allowance
Frame as provided by VSP	24 months	\$10 (lenses and/or frame)	Covered up to \$120 allowance	Up to \$47 allowance
Contact Lenses*	12 months		Covered up to \$105 allowance	Up to \$105 allowance
*Your allowance applies to the cost of your contact lens exam and your contact lenses. You'll receive a 15 percent savings off the cost of your contact lens exam from a VSP doctor. Your contact lens exam is in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts. You may get regular glasses (frames and lenses) 12 months after you get contact lenses.				

Kaiser Vision Plan	
Vision Benefit	Co-pay/Allowance
Eye refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses	\$5 per visit
Regular plastic eyeglass lenses every 24 months	\$100 Allowance*
An eyeglass frame every 24 months	
Medically necessary contact lenses	No charge
*An allowance is the total expenses of an item that is covered. If the cost of the item you select exceeds the allowance, you must pay the difference	

10.3 Prescription Safety Glasses

All active eligible Participants will be covered for prescription safety glasses according to the benefit charts on page 53. The benefits indicated are provided through Vision Service Plan (VSP) doctors. Note: Dependents are not covered for prescription safety glasses. The benefits described under Article 10.4: Using the Plan are for Active Participants enrolled in either UnitedHealthcare HMO Plan or the Anthem Blue Cross PPO Plan.

10.4 Using the Plan

To obtain vision care from the Vision Service Plan, do the following:

1. Contact the Membership Services Department at the Administrative Office for a VSP brochure, or call your VSP doctor. If you need to locate a VSP doctor, call VSP at (800) 877-7195 or visit their web site at www.vsp.com. If you would like a list of VSP doctors (optometrists and ophthalmologists) near where you live, a list will be sent to you.
2. When making an appointment, identify yourself as a VSP member. The VSP doctor will also need the covered Participant's identification number (usually the Participant's Social Security Number), and the covered Participant's group name. The VSP doctor will contact VSP to verify your eligibility and Plan coverage. The VSP doctor will also obtain authorization for services and materials. If you are not eligible, the VSP doctor will notify you.
3. At your appointment, the VSP doctor will conduct an eye examination and determine if corrective eyewear is necessary. If so, the VSP doctor will submit your prescription to a VSP-approved, contract laboratory. The VSP doctor will itemize any non-covered charges and have you sign a form to document that you received the services. VSP will pay the VSP doctor directly, according to their contract agreement, less any co-payments you may be required to pay as set forth above.
4. Selecting a doctor from the VSP list assures direct payment to the doctor and a guarantee of quality and cost control. However, if you seek the services of a provider who is not a VSP doctor, you should pay the provider his/her full fee at the time of service and submit your receipts to VSP. VSP will reimburse you directly in accordance with the schedule of allowances. VSP will not reimburse the non-VSP provider.

There is no assurance that this schedule will be sufficient to pay for the examination or the glasses. When you obtain service from a provider who is not a VSP doctor, and/or glasses from a dispensing optician, be sure to mail your itemized statement of charges to VSP so VSP can reimburse you directly. All claims must be submitted within six (6) months of the date services are completed.

10.5 Non-Panel Providers

If you do not wish to seek services from a doctor who is a member of the VSP network, you may go to any other licensed vision provider, pay the provider his/her full fee, and be reimbursed by VSP in accordance with the reimbursement schedule listed in the "Schedule of Benefits" above.

To receive reimbursement, you need to send your itemized receipt to VSP within six (6) months from your date of service. You should include the covered Participant's name, phone number, address, member ID, the name of the group, the patient's name, date of birth, phone number and address, and the patient's relationship to the covered member (such as spouse, child, etc.) along with your itemized receipt. Please keep a copy of the information for your records and send the originals to the following address:

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

10.6 Limitations

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

1. Blended lenses;
2. Contact lenses (except as noted elsewhere herein);
3. Oversize lenses;
4. Progressive multifocal lenses;
5. Photochromic lenses or tinted lenses other than Pink #1 or #2;
6. Coated lenses;
7. Laminated Lenses;
8. A frame that costs more than the Plan allowance;
9. Certain limitations on low vision care;
10. Cosmetic lenses;
11. Optional cosmetic processes; or
12. UV protected lenses.

Not Covered. There is no benefit for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing.
2. Plano lenses (non-prescription).
3. Two (2) pair of glasses in lieu of bifocals.

4. Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
5. Medical or surgical treatment of the eyes.
6. Any eye examination, or any corrective eyewear, required by an Employer as a condition of employment.
7. Corrective vision services, treatments, and materials of an experimental nature.

10.7 Complaints

If you have a complaint regarding VSP's service or claim payment, you should send a complaint to VSP by using the complaint form which is available in all VSP doctor offices as well as from the Administrative Office. You may call VSP's toll-free Customer Care Division at (800) 877-7195, Monday through Friday, 5:00 a.m. to 7:00 p.m., Pacific Standard Time. You should send the complaint form to:

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670-7985

Article 11: Additional Benefits (Medical Body Scan and Specialized Footwear)

This Plan provides Participants with the following additional medical benefits:

11.1 Medical Body Scan Benefit

The Medical Body Scan Benefit is available to Participants and Eligible Spouses under the Southern California IBEW-NECA Health Trust Fund Active Summary Plan Description. The Medical Body Scan Benefit is provided exclusively at this time through Body Scan International (“BSI”).

Each Eligible Participant and Dependent Spouse is entitled to one Medical Body Scan Benefit per calendar year. The Medical Body Scan Benefit is provided at no cost to Participants. BSI will submit your claim for the Medical Body Scan Benefit directly to the appropriate claim administrator: Coast Benefits, Inc. for HMO Participants; and Anthem Blue Cross for Participants in the Anthem Blue Cross PPO Plan.

To schedule an appointment for the Medical Body Scan Benefit, Participants must call BSI at (877) BSI-5577 [877-274-5577]. Please note that you must be eligible for coverage at the time of your body scan appointment to receive the Body Scan Benefit under the Plan.

BSI performs the Medical Body Scan examination at its offices located at 20162 SW Birch Street, Suite 100, Newport Beach, California 92660. In addition BSI will perform the Medical Body Scan examination at its mobile units which will be parked from time to time at various locations in the Los Angeles Metropolitan Area. Please note that advance appointments are also required for Medical Body Scan examinations at the mobile units and the same restrictions apply in terms of eligibility.

BSI also provides **other services that are not part of the Plan’s Medical Body Scan Benefit**. Please note that payment for those other services will be your responsibility since they are not covered under the Body Scan Benefit unless they are otherwise eligible expenses.

If you obtain a body scan through another provider (other than BSI), the Plan will not pay for any portion of the medical body scan examination.

If you have any questions regarding the Body Scan Benefit, please contact Body Scan International at (877) 274-5577 or (949) 717-4500. If you have questions about your eligibility for this benefit, please contact the Administrative Office at (800) 824-6935 or (323) 221-5861.

11.2 Specialized Footwear Benefit

The Plan provides benefits for specialized footwear, sometimes known as “orthotics.” The annual benefit of \$400 may be used to defray the costs of consulting with a certified orthotist or other provider certified by the American Board for Certification in Orthotics, Prosthetics and Pedorthics and the cost of fabricating and fitting the specialized footwear. Specialized footwear includes orthopedic shoes and custom-made, rigid plastic or polypropylene inserts for the shoe.

This benefit is available to all eligible Participants and eligible dependents enrolled for medical benefits under the Plan. Participants enrolled in the Kaiser HMO Plan may utilize this benefit or they may choose to obtain orthotics through Kaiser.

Eligible expenses subject to reimbursement shall include expenses for the professional services provided by an orthotist, prosthetist, pedorthist or other provider certified by the American Board for Certification in Orthotics, Prosthetics and Pedorthics when professional services are in connection with the treatment of foot disfigurement. For purposes of this benefit, foot disfigurement means foot disfigurement resulting from cerebral palsy, arthritis, polio, spina bifida, diabetes, accidental injury or abnormal condition.

A. Eligible Services

Eligible services for specialized footwear shall include the cost of fabricating custom-made rigid (plastic or polypropylene) foot orthotics (shoe inserts) and/or custom-made standard orthopedic shoes.

B. Maximum Annual Benefit

The maximum annual benefit payable per eligible Plan Participant and eligible dependents for eligible expenses incurred for the procurement of specialized footwear shall be \$400.

C. Submission of Claims

Claims for eligible expense reimbursement under this provision shall be submitted to Coast Benefits Inc at:

Coast Benefits, Inc.
3444 Camino Del Rio North, Suite 101
San Diego, CA 92108

Claims must include the name and address of the provider, the date services are rendered, the diagnosis or condition being treated, and an itemized listing of services rendered.

Reimbursement shall be made directly to the Participant or Member and not to the provider.

D. Exclusions

No benefits shall be provided under the terms of this provision for:

1. Dress shoes;
2. Casual shoes (e.g., tennis shoes or deck shoes);
3. Shoe inserts (except as provided above);
4. Foot pads;
5. Foot orthotics that are fabricated from soft plastic, cork or leather;

6. Socks or any supplies that are not custom-made or of which the equivalent can be purchased without prescription; or
7. Services provided to Participants that do not suffer from foot disfigurement as defined above under “Eligible Expenses.

Article 12: Advocacy and Assistance Services Program

12.1 MedExpert

The Trustees have contracted with MedExpert to assist you and your eligible dependents with advocacy and assistance services, whereby Personal Health Advocates (PHA's), typically registered nurses, supported by medical directors and benefit specialists will work with you and /or your eligible dependents to:

- Find physicians, medical specialists and other providers.
- Assist in understanding and resolution of billing for medical, dental or other professional services.
- Facilitate referrals for covered services.
- Clarify Plan coverage.
- Transfer medical records.
- Locate elder care

You may contact MedExpert at (800) 999-1999.

12.2 MedExpert Services

MedExpert services will complement the benefits delivered through your Plan by assisting you and your eligible dependents with health care providers and community-based services, locating the best health care providers within the Plan's parameters, and provide assistance with the resolution of insurance claims issues, etc.

MedExpert representatives may contact you or your eligible dependents to accomplish the aforementioned tasks. Your cooperation and assistance are greatly appreciated. In addressing a participant issue, MedExpert may act as a liaison between you or your eligible dependent and the insurance vendor/provider who contracts with the Trust.

MedExpert does not replace health insurance coverage, does not provide medical care or recommended treatment, and does not duplicate key benefit plan provider functions. MedExpert helps connect you and your eligible dependents to existing services such as case management, disease management, wellness, EAP and other in-place services.

Article 13: Member Assistance Program (MAP)

The **Member Assistance Program (MAP)** is provided to all Active Participants (and their covered dependents as well as other household members) enrolled in the Kaiser HMO Plan, the UnitedHealthcare HMO Plan and the Anthem Blue Cross PPO Plan.

Optum is the health services division of UnitedHealth Group

(877) 225-2267 (877-22-LABOR) 24-hours-a-day

All Services are completely confidential.

The Member Assistance Program

The Board of Trustees has implemented a Member Assistance Program (MAP) which is available to you and your dependents (spouse or other family members) to receive confidential help for a wide range of personal and work-related concerns at no cost to you.

Through the MAP program, you can receive a referral to a licensed behavioral health professional for up to three (3) face-to-face counseling sessions per Participant, per problem at no charge to you.

Getting Started: Call Optum

All services covered under this Member Assistance Program must be provided by an Optum Participating Provider and must be pre-authorized.

To get a referral to a MAP counselor, call the **Optum Customer Service Department 24-hours-a-day at (877) 225-2267 (877-22-LABOR)**.

*You **do not** need a referral from your Primary Care Physician to get services under the Member Assistance Program.*

How the MAP Can Help You

The Member Assistance Program (MAP) assists Participants with emotional, relational, or behavioral health concerns including:

- Relationship and marital issues, including communications problems and conflict resolution
- Family problems, such as parent/child conflicts, single parenting issues, child and adolescent problems, spousal abuse, incest
- Alcohol and drug abuse, including codependency
- Work-related problems, such as job stress, burnout, interpersonal and situational conflicts, adjustment issues

- Emotional problems and personal issues, including anxiety, depression, personal crises, grief and loss, life change issues
- Disease-related issues, such as coping with chronic and terminal illness, grief and loss

The MAP also provides extensive services for individuals needing help with non-clinical issues, such as credit card debt, divorce, child custody matters, or shelter from abusive relationships. Through the array of support we provide, we can help you meet virtually any challenge you may face.

13.1 Legal Assistance

Participants with legal problems are provided either a free 30-minute telephonic or in-person consultation with a state-specific attorney as part of our MAP services, including legal assistance with the following: wills, deeds, document preparation, probate matters, divorce and separation, trusts, living wills, power of attorney, immigration and traffic matters.

13.2 Financial Services

To help individuals address financial concerns, we offer access to a team of credentialed financial consultants, including licensed CPAs and Certified Financial Planners, who have at least five (5) years of financial services experience. Participants receive up to 60 minutes of telephonic consultation regarding each financial issue. Optum members may call for assistance on a wide range of topics, including the following: Bankruptcy, budget planning, credit and collections, financial planning, retirement planning, mounting debts, wage garnishments, investments, mutual funds, IRAs, stocks and bonds, annuities, taxes and home buying.

13.3 Child and Family Services

Family life is a 24-hour commitment. Your MAP can help. Member Assistance Specialists can provide referrals to community child and elder resource and referral agencies and to geriatric services, as needed by our members. Services your MAP can help with include: verified childcare referrals, sick child care, before and after school programs, parenting support groups and classes, blended families, newborn issues, college planning, starting a family, pregnancy and infertility, adoption, prenatal and childbirth classes, single parenting, teen communication and support and much more.

13.4 Eldercare

Eldercare specialists within your MAP program can provide you with guidance for caring for older relatives, alternative care living options and exploration, adult day care programs, assistance with meals and transportation, elder abuse resources, grief and loss, home health assessments, senior center information, geriatric referrals, hospice care and much more.

13.5 Community Resources

We maintain an internally developed database of more than 100,000 community resources, which are verified every three (3) months by our internal dedicated resource and referral staff.

Available resources include the following: 12-step programs, support groups, self-help groups, AIDS-related assistance, community mental health agencies, geriatric services, United Way agencies, battered women's shelters, family service agencies and child abuse services.

13.6 Internet Resources

Through the Optum MAP website www.liveandworkwell.com (access code: SCIBEW), all members have access to a wide variety of information, self-help programs, personal assessments, and resources and articles on a wide variety of topics. The website is available in English or Spanish, with functionality that allows you to toggle back and forth on each page between languages.

13.7 Exclusions and Limitations

Your MAP does not cover any of the following:

1. Physician services, including services from a psychiatrist
2. Hospital services (inpatient and outpatient services)
3. Diagnostic laboratory and diagnostic and therapeutic radiological services
4. Home health services
5. Emergency health care services
6. Drugs and medications

For more information about your MAP Program, call the Optum Customer Service Department at (877) 225-2267 (877-22-LABOR) 24-hours-a-day.

Article 14: Life and Accidental Death and Dismemberment Insurance Benefits

Please note that this is only a summary of the Life and Accidental Death and Dismemberment benefits available under the Anthem Blue Cross insurance policy. Please refer to your Evidence of Disclosure/Certificate of Insurance document for a complete description of the Life and Accidental Death and Dismemberment benefits, including the exclusions and limitations and any applicable provisions. **An Evidence of Disclosure/Certificate of Insurance may be requested directly from Anthem Blue Cross at (800) 543-3037 or from the Administrative Office. This information is also available on the Administrative Office website at www.scibew-neca.org.**

14.1 Schedule of Life Insurance Benefits

Life insurance benefits are normally payable upon the death of the covered Participant or covered dependent. However, a portion of the life insurance benefits may be payable in certain circumstances before the death of the covered Participant. This option is referred to as the “Accelerated Benefit Option.”

The amounts shown below are the maximum amounts payable as subsequently explained.

A. Participant Only

Life Insurance	\$50,000
Accidental Death, Dismemberment Insurance	\$50,000

The Accidental Death and Dismemberment Insurance of each Employee will automatically terminate on the date eligibility ceases and may not be converted to an individual policy.

B. Life Insurance for Dependents

Spouse	\$1,500
Children to age 26	\$750

The Dependent Effective Date Proviso shall apply if a child is then confined to a hospital.

14.2 Schedule of Accidental Death and Dismemberment (AD&D) Insurance Benefits

A. Participant Only

Accidental Death and Dismemberment Insurance.....	\$50,000
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The Accidental Death and Dismemberment Insurance of each Employee will automatically terminate on the date eligibility ceases and may not be converted to an individual policy.

14.3 Group Policyholder

Trustees of the Southern California IBEW-NECA Health Trust Fund

Group Policy Number: 170001

President

Anthem Blue Cross Life and Health Insurance Company

Woodland Hills, CA (herein called Anthem Life)

14.4 Notice and Proof of Claim

Written notice of a medical or health insurance claim must be given to Anthem Life at least 45 days before the end of the calendar year which follows the calendar year in which the claim is incurred. However, in the event that medical or health insurance ends, notice of claim in writing must be given no later than 12 months after such claim was incurred. Written notice of any other type of accident and sickness claim must be given to Anthem Life at its home office or an authorized claim office or to an agent. Notice should include the name of the insured individual and the policy number.

Loss, as used in this provision, means covered expenses incurred, disability or accidental death or dismemberment.

Positive proof of claim must be given to an authorized claim office of Anthem Life, pursuant to the procedures set forth in the Anthem Blue Cross Life Insurance “A Guide to your Benefits”, which can be found on the Administrative Office’s website at www.scibew-neca.org.

Article 15: Plan Amendment Procedures

15.1 Changing, Enhancing, Reducing, or Eliminating Benefits

There is no vested right to receive Plan benefits. What this means is that the Board of Trustees may change, enhance, reduce or eliminate benefits at any time. The Board of Trustees has a fiduciary responsibility to prudently manage the Plan. In order to meet this responsibility, the Trustees periodically review the cost and benefits of the various Plans. As a result of this review, the Trustees may find it necessary to change, reduce or eliminate benefits.

The following examples provide information on situations, which may necessitate the Trustees reducing benefits. For example, a reduction in total hours worked results in reduced Employer contributions to the Plan, and alters the projected hours used to establish benefits. Another example occurs when Plan costs for a specific benefit increase more than projected, requiring a reduction in the benefit allowance.

15.2 Notification of Plan Changes to Participants

The Trustees reserve the right to change or discontinue any Plan benefits, in whole or in part, as they deem such action necessary.

Such action by the Trustees will be accomplished by a Plan Amendment, which details in writing the changes made.

You will be provided a written notice when such changes to the Plan (Plan Amendment) are made. This notice will describe in detail the changes and will be provided to you no less than 60 days prior to the effective date of any change which discontinues, reduces, or eliminates a benefit.

Article 16: Retiree Health Plan Eligibility

16.1 Eligibility

IF YOU WISH TO PROTECT YOUR POTENTIAL ELIGIBILITY FOR RETIREE HEALTH COVERAGE, NEVER COMMENCE YOUR PENSION UNTIL RETIREE HEALTH PLAN ELIGIBILITY IS CONFIRMED IN WRITING BY THE ADMINISTRATIVE OFFICE BASED UPON YOUR PROPOSED PENSION EFFECTIVE DATE. RETIREMENT PRIOR TO AGE 56 WILL AFFECT YOUR ELIGIBILITY FOR RETIREE HEALTH PLAN BENEFITS

A full explanation of the Retiree Health Plan eligibility requirements is set forth in a separate Retiree Health Plan Summary Plan Description which the Administrative Office will provide you upon request. Certain collective bargaining agreements do not include contributions for Retiree Health Plan coverage. The Administrative Office can provide, upon request, a listing of those collective bargaining agreements which do not provide contributions for Retiree Health Plan coverage.

Before commencing the receipt of your Retiree Pension Plan benefits, you should contact the Administrative Office and receive written confirmation of your eligibility to enroll in the Retiree Health Plan. Also, note that participation in the Retiree Health Plan is not automatic; you must apply for and enroll in the Retiree Health Plan. If you will be maintaining eligibility for Active coverage by using the accumulated hours in your Hours Bank Reserve, you should monitor those hours carefully after you retire to make sure you apply for and enroll in the Retiree Health Plan before your Hours Bank Reserve is exhausted. If you exhaust your Hours Bank Reserve you should continue Active coverage by electing COBRA continuation coverage, and, upon the termination of your COBRA continuation coverage, apply for and enroll in the Retiree Health Plan.

An eligible spouse enrolled in the Retiree Health Plan may continue his/her coverage under the Retiree Health Plan upon the Retiree's death. An individual who has retired under the Southern California IBEW-NECA Pension Plan and meets all of the eligibility requirements under this Retiree Health Plan may delay enrollment in this Retiree Health Plan until the later of exhaustion of Hours Bank Coverage and/or COBRA coverage under the Active Plan. If during this permitted delay in enrollment such an individual shall die, his or her otherwise eligible spouse may enroll in the Retiree Health Plan no later than the exhaustion of Hours Bank Coverage and/or COBRA coverage under the Active Plan.

Benefits under the Southern California IBEW-NECA Retiree Health Plan are partially financed through Employer contributions that are specifically designated to provide health benefits for retired Participants. The HRA balance in a participant's account may be used to make Retiree Health Plan self-payments if the participant is eligible for Retiree Health Plan coverage, had contributions paid into the Plan for the participant's HRA and funds are currently available for premium payments commencing after September 1, 2017. You have no vested right to receive Retiree Health Plan benefits. The Trustees may change, modify, reduce or terminate the Retiree Health Plan's benefits and required self-payment at any time as a result of conditions or events requiring such action.

Effective with Retiree Health Plan initial enrollment for pensions commencing on or after April 1, 2017, the requirements are as follows:

A. Age/Pension and Service Requirements:

Early Retirees are eligible if they have attained age 56 at their Annuity Starting Date, are awarded an unreduced early retirement benefit from the Southern California IBEW-NECA Pension Trust Fund, and have had at least 44,500 hours worked under a collective bargaining agreement requiring Retiree Health Plan contributions to this Plan (includes Health hours credited through reciprocity), and of those hours 10,500 hours must have been worked in seven (7) of the 10 years prior to retirement.

Normal Retirees are eligible if they retire and have their Annuity Starting Date on or after age 62 under the Southern California IBEW-NECA Pension Trust Fund. Retiree Health Plan eligibility is limited to such individuals who have at least 10 years of credited service under the Pension Plan and have had 10,500 health hours under a Collective Bargaining Agreement requiring Retiree Health Plan contributions (includes Health hours credited through reciprocity) in seven (7) of the 10 years immediately preceding the date of retirement.

B. Timely Application and Payments:

In addition to each of the requirements stated above, you must request and complete an application, enroll by no later than the later of the date your first pension check was issued or your loss of eligibility under the Active Health Plan, and pay the monthly medical premium. The monthly medical premium may be deducted from your monthly Southern California IBEW-NECA Pension Trust Fund benefit OR monthly self-payments may be made to the Southern California IBEW-NECA Health Trust Fund. The HRA balance in a Participant's account may be used to make Retiree Health Plan self-payments if the participant is eligible for Retiree Health Plan coverage, had contributions paid into the Plan for the Participant's HRA and funds are currently available for premium payments commencing after September 1, 2017.

C. Delayed Enrollment:

An individual who has retired under the Southern California IBEW-NECA Pension Trust Fund and meets all of the eligibility requirements under the Retiree Health Plan may delay enrollment in the Retiree Health Plan until the later of the exhaustion of the Hours Bank Reserve and/or exhaustion of COBRA coverage under the Active Plan. If during this permitted delay in enrollment such an individual shall die, his or her spouse may enroll in the Retiree Health Plan no later than the exhaustion of the Hours Bank Reserve and/or the exhaustion of COBRA coverage under the Active Plan. See Article 16.2: HIPAA Special Enrollment Rights (Exception to the Deadline for Retiree Health Plan Enrollment) for more information.

D. Total Disability and/or Partial Disability Benefits and Crediting of Disability Hours:

Total Disability and/or Partial Disability Benefits and Crediting of Disability Hours for Retiree Health Plan eligibility are not available to individuals retiring on or after April 1, 2017. Initial Retiree Health Plan benefits through the Maintenance Agreement after retirement will no longer be available effective April 1, 2017.

NOTE: *Nothing in the eligibility requirements set forth above impacts those individuals who met the Retiree Health Plan's eligibility rules and commenced to receive a benefit from the Southern California IBEW-NECA Pension Plan on or before March 31, 2017.*

16.2 HIPAA Special Enrollment Rights (Exception to the Deadline for Retiree Health Plan Enrollment)

- A. Under HIPAA you have the right to enroll in the Retiree Health Plan subsequent to the commencement of your pension benefit so long as your initial declination to enroll in the Retiree Health Plan when first eligible to do so is due to your having other health coverage in force at that time, and the following conditions are met.
- B. The Administrative Office must receive your signed declination prior to the expiration of the normal 30-day initial enrollment deadline for enrolling in the Retiree Health Plan.
- C. You will lose your HIPAA Special Enrollment rights if a properly completed and signed declination is not received within 30 days prior to expiration of your initial enrollment deadline under the Retiree Health Plan.
- D. If the Administrative Office receives your initial and properly completed declination in a timely manner, your subsequent enrollment in the Retiree Health Plan must occur within 30 days of the loss of your other health coverage which was the basis of your declination.

If you have properly and timely declined initial enrollment in the Retiree Health Plan, you may still lose your HIPAA Special Enrollment rights if you fail to enroll in the Retiree Health Plan within 30 days of the loss of your other health coverage. You must submit proof of your period of coverage under your other health coverage when you apply for enrollment in the Retiree Health Plan.

You are not required to fully exhaust COBRA coverage prior to enrolling in the Retiree Health Plan. You are entitled to enroll in the Retiree Health Plan upon timely application at the beginning of any month during the COBRA continuation coverage period.

If you have questions, please contact the Administrative Office at (323) 221-5861, Monday through Friday or toll free at (800) 824-6935 from 8:30am – 5:30pm.

Article 17: Eight Federal Laws You Should Know About

The following are discussed in this Article:

1. Consolidated Omnibus Budget Reconciliation Act (COBRA)
2. Family and Medical Leave Act (FMLA)
3. Health Insurance Portability and Accountability Act (HIPAA)
4. Newborns' and Mothers' Health Protection Act
5. Women's Health and Cancer Rights Act (WHCRA)
6. Qualified Medical Child Support Order (QMCSO)
7. Mental Health Parity and Addiction Equity Act (MHPAEA)
8. Uniformed Services Employment and Reemployment Rights Act (USERRA)

17.1 COBRA

A. Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (commonly referred to as "COBRA"), requires that this Administrative Office offer you and your eligible Dependents the opportunity to continue health care coverage at group rates when coverage under this Plan would otherwise end due to the occurrence of what are called "qualifying events". Continued coverage under COBRA applies to the health care benefits (medical, dental, and prescription drug and vision benefits) described in this Summary Plan Description.

Your group health benefits under COBRA will be the same as those covering you on the day before you lose coverage under this Plan. (COBRA does not apply to your life insurance benefits under this Summary Plan Description.) You should also keep in mind that each individual entitled to COBRA coverage as the result of a loss of group coverage due to the occurrence of a qualifying event has a separate and independent right to make his or her own election of coverage. For example, your spouse or other covered Dependent could elect COBRA coverage even if you do not.

IMPORTANT: If you choose to continue your health care coverage as explained below, you will have to make a payment each month to the Administrative Office within the time periods explained below. The Administrative Office does not send bills for COBRA coverage. It is your responsibility to make COBRA payments on time. If you don't make your payment on time, your coverage will end.

Under COBRA, you have 60 days from the date you lose coverage because of the occurrence of certain qualifying events to inform the Administrative Office that you want to elect COBRA continuation coverage. Once you receive the COBRA election notice from the Administrative

Office you will then have sixty days to notify the Administrative Office that you are electing COBRA continuation coverage. If you don't elect COBRA within that 60-day period, you will forfeit your rights as a qualified beneficiary to elect COBRA. You must make your first payment for COBRA continuation coverage to the Administrative Office within 45 days after you first elect COBRA coverage. If you do not make your initial COBRA premium payment in full within the 45-day period, the Administrative Office will terminate your COBRA coverage and you will not be able to reinstate that COBRA coverage.

When you make your first COBRA premium payment, you must pay for all months of coverage which are due through the end of the month in which you make your first payment. Your payment for subsequent months is due on the first of each month. The Administrative Office will terminate your COBRA coverage for non-payment if the Administrative Office does not receive your COBRA premium payment within 30 days after the applicable month's due date. For example, a payment for the coverage month of January is due January 1st. If payment is not received in the Administrative Office by January 30th, the Administrative Office will terminate your COBRA continuation coverage. If this happens, there would be no coverage for the month of January, or any additional months for which COBRA benefits may have been available.

You, your spouse, and children should read this section carefully. The following information explains both your rights and your obligations under COBRA. If you have any questions, contact the Administrative Office. The telephone number and address are printed under the "Summary Plan Description General Information" in the front of this booklet.

B. Subsidized COBRA

The subsidized COBRA program is partially funded through employer contributions. There is no vested right to subsidized COBRA benefits and the Trustees may change, modify, reduce or terminate these subsidized benefits at any time as a result of conditions or events requiring such action.

For certain Participants and beneficiaries, the required COBRA self-payment is \$50.00 per month for the first three (3) consecutive months of continuation of "Basic Coverage" consisting of hospital/medical and prescription drug benefits. If you are eligible to do so, you may also choose to continue dental and vision benefits under COBRA for an additional cost. Thereafter, on the fourth month of COBRA continuation coverage, you must self-pay at the full premium cost allowed by COBRA. COBRA does not apply to any life insurance benefits you may have under the SPD.

The eligible dependents of an eligible Participant losing coverage due to the Participant's death are eligible for the subsidized rate (if the Participant would have been eligible for this rate) for the first three (3) consecutive months of continuation of "Basic Coverage," consisting of Hospital, Medical and Prescription Drug benefits. If the eligible dependents choose to continue dental and vision benefits under COBRA, there is an additional cost. Thereafter, on the fourth month, the eligible dependents must self-pay at the full premium cost allowed by COBRA.

The following are examples of persons who are not eligible for the subsidized rate:

1. Participants receiving a pension from the Southern California IBEW-NECA Pension Plan and their Dependents;
2. Participants who are classified as Designated Working Members;
3. Spouses and stepchildren losing coverage due to divorce;
4. Children losing coverage due to attainment of an age beyond a maximum age permitted for dependent coverage under this Plan;
5. Participants who are employed by an employer who are permitted to receive increased wages in lieu of health coverage;
6. Participants who decline to reciprocate Contributions to the Southern California IBEW-NECA Health Trust Fund while employed by an Employer that contributes to a trust fund or fund that is signatory to the International Reciprocal Agreement;
7. Participants whose eligibility is terminated due to Non-Covered Electrical Employment.

It is important to remember that while Participants, spouses and children have separate and distinct COBRA election rights, the election of COBRA by a Participant automatically provides COBRA coverage for the Participant's eligible Dependents and the election of COBRA by any parent automatically provides COBRA coverage for the parent's eligible children.

You will again be eligible for the COBRA self-payment of \$50.00 per month after you have reestablished your Hours Bank Reserve to a maximum of 600 hours. The Hours Bank Reserve is explained in Article 4.3: Hours Bank Reserve.

The Trustees will not necessarily continue to offer the subsidized COBRA self-payment of \$50 for the first three (3) consecutive months. The Trustees do not guarantee to subsidize the cost of COBRA coverage, and they may discontinue or reduce the amount of the subsidy at any time, provided they give all Plan Participants with 60 days' notice of any change to the subsidy program. You can pay the monthly premium. However, a third party such as a hospital or your new employer may also pay the premium.

C. At a Glance - Qualifying Events That Entitle You to COBRA

If you Lose Coverage Because of This Reason (a “qualifying event”)	These People Would Be Eligible If Covered Under the Plan on the Day Before the Qualifying Event	For COBRA Coverage Up To (Measured from the date coverage is lost)
Your employment terminates*	You and your covered spouse and covered children	18 months**
Your working hours are reduced	You and your covered spouse and covered children	18 months**
You die	Your covered spouse and covered children	18 months to a maximum of 36 months
You divorce or legally separate	Your former spouse and your covered stepchildren	18 months to a maximum of 36 months
Your dependent child (who reaches age 26), no longer qualifies as an eligible dependent	Your covered child	18 months to a maximum of 36 months
You become permanently disabled	Your covered spouse and covered children	18 months to a maximum of 29 months

*For any reason (and including military leave and approved leaves granted under the Family and Medical Leave Act (FMLA). Note that under FMLA, your employment terminates at the end of the approved leave if you do not return to work.

** Continued coverage for up to 29 months from the date of the initial event may be available to those who are or become totally disabled within the meaning of Title II, or Title XVI of the Social Security Act at any time during the first 60 days of COBRA continuation coverage. This additional 11 months of COBRA coverage is available to Employees and enrolled Dependents if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of COBRA coverage may increase to a maximum of 150% of the full cost of the elected coverage. Additionally, coverage can be extended for eligible Dependents for up to a maximum of 36 months in the event of a second qualifying event prior to the initial termination of COBRA coverage if the second qualifying event results in a loss of coverage. Examples would be the death of the Employee, the divorce or legal separation of the Employee if the divorce or legal separation results in a loss of coverage under the Plan, or the Employee attaining initial eligibility for Medicare coverage.

D. Notification

A Participant or a Family Member has the responsibility to inform the Administrative Office of a divorce, legal separation, or a child losing dependent status under the Plan within **60 days of the qualifying event**. If you fail to notify the Administrative Office of a divorce, legal separation, or a child losing dependent status within the 60-day period, the affected dependent will lose the

right to elect COBRA continuation coverage. A qualifying event means the reason you are losing eligibility under one of the situations described above, such as termination of a Participant's employment. Another example of a qualifying event for a legal spouse would be divorce. For a dependent, he or she may turn age 26 and no longer be an eligible dependent under Plan rules.

When the Administrative Office is notified that one of these events has happened, the Administrative Office will, in turn, notify you that you have the right to elect COBRA continuation coverage. This notice will also explain the monthly payment you must pay to continue your health coverage. Under COBRA, you have at least 60 days from the date you would lose coverage, because of one of the qualifying events described above, to inform the Administrative Office that you want to elect COBRA continuation coverage.

Children born or adopted during the Participant's period of continuation coverage are considered Dependents, the same as those of active eligible Participants. Remember, you must enroll your newborn or adopted child within 31 days of the birth or placement for adoption. Contact the Administrative Office for the necessary forms to enroll this new Dependent.

If you do not elect to continue coverage or if you do not make the required self-payment by the applicable due date, your coverage under this Plan will end. You will not be able to elect COBRA Continuation Coverage at a later date.

E. Benefits and Length of Coverage

If you choose "Basic" COBRA coverage, it will be the same hospital/medical/prescription drug coverage that you had under the Plan on the day before the occurrence of the qualifying event which resulted in your loss of coverage under this SPD. A qualified beneficiary is entitled to up to 18 months of COBRA coverage if the qualifying event is termination of employment or a reduction of employment hours. This may be extended for up to an additional 11 months, for a total of 29 months if the Social Security Administration finds that a qualified beneficiary (either the Participant or the spouse or dependent child) is disabled at any time during the first 60 days of COBRA coverage. To implement this special 11-month extension, the disabled qualified beneficiary must notify the Administrative Office within 60 days following the latest of the date on which the individual receives the initial COBRA notice following a qualifying event, the date Social Security determines that the individual is disabled, the date of the qualifying event, or the date on which the qualified beneficiary loses (or would lose) coverage due to the occurrence of the qualifying event. In any event, you must provide the notice of disability before the end of the initial 18-month COBRA coverage period arising from the Participant's termination of employment or reduction in hours of employment. The occurrence of another qualifying event during the initial 18-month (or 29 month) COBRA coverage period may increase the maximum COBRA coverage period to 36 months (maximum).

If another qualifying event (such as a divorce or legal separation or the death of the Participant) occurs during the 18-month COBRA coverage period (or during the 29-month COBRA coverage period in the case of a disability extension), the spouse or dependent children may be entitled to an extension of the COBRA coverage period to up to a total of 36 months (the maximum

COBRA coverage period under the law). In no case, may the total maximum COBRA coverage period arising from an initial or related qualifying event be more than 36 months.

F. Cancellation of Your COBRA Coverage

Your COBRA coverage will be terminated at the end of the maximum applicable COBRA coverage period or prior to the end of the maximum COBRA coverage period for any of the reasons explained below.

1. The Board of Trustees terminates a particular coverage for all Participants of the Plan. If coverage is changed or eliminated, persons on COBRA only have the right to choose among the options offered to similarly situated non-COBRA beneficiaries;

For example, if the Trustees were to terminate an HMO contract under which you were covered under COBRA, and another HMO was offered to all other Plan participants who were previously enrolled in the canceled HMO, you would be allowed to enroll in the replacement HMO.

2. You request that your COBRA coverage be canceled. If you request termination, the COBRA coverage will generally end on the first day of the month following completion of a 30-day period beginning on the date the Administrative Office received your written request to cancel the COBRA coverage. For example, if the Administrative Office received your letter on May 15, the 30-day period would end on June 15, and the COBRA coverage would end July 1. In this situation, you would be required to pay for the COBRA coverage through the month of June;
3. If your COBRA premium is not paid in a timely manner, your coverage will be canceled. The cancellation will be retroactive to the beginning of the month following the end of the month for which you last made a timely COBRA premium payment. If you have received any benefits or services in the period of time following the cancellation of your COBRA coverage, you may be required to repay to the carrier the amount of the benefits received or the cost of the services rendered;
4. The date on which the qualified beneficiary first becomes, after the date of election, covered under any other group trust fund (as an employee or otherwise) provided that the other trust fund does not contain any exclusion or limitation for any pre-existing condition which affects the coverage of the qualified beneficiary covered under the new trust fund. Note that a qualified beneficiary may not be denied the right to elect COBRA coverage because they are covered under another group trust fund at or before the time they make their COBRA election under this Plan;
5. You become entitled to Medicare benefits after COBRA coverage has been elected;
6. You are no longer disabled. If a qualified beneficiary is determined to no longer be disabled under the Social Security Act before the end of the 29-month maximum coverage period, COBRA coverage may be terminated at the beginning of the first month that begins more than 30 days after such determination is made;

7. The signatory Employers to the Plan no longer provide group health coverage benefits to any of its Employees;
8. The Plan is terminated.

G. Dependent/Spouse Address Change

Contact the Administrative Office if you or your dependents change address(es).

17.2 Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act enacted by Congress in 1993 (FMLA) 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. The federal legislation specifically provides that more liberal provisions of state law are permitted and also provides that more liberal provisions contained within collective bargaining agreements are permitted.

It is not the role of the Trustees or Administrative Office to determine whether or not an individual Employee is entitled to leave with continuing medical care under the federal FMLA statute, any state statute or the provisions of a Collective Bargaining Agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the Employer, Employee and where applicable, the Local Union.

To the extent that Participants are entitled to leave with continuing medical coverage pursuant to the federal FMLA statute, state legislation or provisions contained within a Collective Bargaining Agreement, the Administrative Office will provide continuing medical coverage so long as required monthly Contributions are received from the contributing Employer. Rights under this section in no fashion affect rights under COBRA or rights to continuing medical care pursuant to the disability extension features contained within the SPD.

17.3 Health Insurance Portability and Accountability Act (HIPAA)

A federal law called the Health Insurance Portability and Accountability Act (HIPAA) requires this Administrative Office to furnish you with certain information.

One purpose of HIPAA is to help families minimize the impact of pre-existing condition exclusions as they move from job to job. A pre-existing condition exclusion allows a trust fund to not cover certain illnesses (for example, a heart condition) until the individual is covered under the trust fund for a designated period of time, typically six (6) to 12 months.

IMPORTANT: The medical plans (Kaiser, UnitedHealthcare, or the Anthem Blue Cross PPO Plan) offered through the Southern California IBEW-NECA Health Trust Fund **do not** contain any pre-existing condition exclusions. You become eligible for benefits under this Plan as explained in Article 4.1: Eligibility: When Coverage Begins on page 13 without regard to any pre-existing medical conditions for which you may or may not have been treated prior to your effective date of coverage under this Plan. All covered benefits become effective on the date you become eligible for benefits under this Plan.

However, each medical plan does have benefit exclusions and limitations for designated illnesses and conditions. For example, each of the three (3) medical plans contains exclusion for experimental surgery. A detailed list of the exclusions for each of the plans is contained in the respective plan's Evidence of Coverage document. Further information can be obtained by contacting the Administrative Office, Anthem Blue Cross PPO or the HMO benefit provider.

A. HIPAA Privacy Rules

The Administrative Office maintains a hands-off policy for managing protected health information ("PHI"). PHI maintained by the Administrative Office of the Trust Fund is limited to names, ages, sex, marital status, eligibility and address information provided through the application and enrollment process. The law specifically limits the permissible use of this information absent your authorization. The Administrative Office does not receive nor maintain any identifiable medical claims information. All your medical claim information is maintained solely by the covered entities with whom the Trust Fund has entered into contracts and the third-party administrators with whom the Trust Fund has entered into contracts.

B. Information You Should Know as Required by HIPAA – Limitations on Benefit Changes in Existing Coverage During a Policy Year

In accord with applicable law except when an insurance policy is renewed you will receive at least 60 days advance written notice of any material reduction in covered services or benefits impacting the programs in which you are enrolled.

Certain benefit plans under the Southern California IBEW-NECA Health Trust Fund have benefits guaranteed under contract between the Board of Trustees and the benefit provider. The following providers have guaranteed benefits by contract with the Board of Trustees or are responsible for administering certain benefits, as in the case of Coast Benefits, Inc.

Medical Plans	Anthem Blue Cross (PPO) Kaiser Permanente (HMO) UnitedHealthcare (HMO)
Dental Plans	CIGNA (DHMO) DeltaCare (DHMO) United Concordia (DHMO and PPO)
Health Reimbursement Arrangement	Coast Benefits, Inc.
Life Insurance	Anthem Blue Cross Life and Health Insurance Company
Vision Insurance	Vision Service Plan
MAP	Optum is the health services division of UnitedHealth Group
Questions/Assistance	MedExpert Program

Each of the above benefit providers or third party administrator maintains an appeals procedure. This appeals procedure is explained in the Evidence of Coverage document or contract provided by each benefit provider or third party administrator. An example of an appeal under an HMO may be where you received emergency care outside the HMO network and the claim was denied by the HMO because they did not deem it an emergency. You can contact the benefit provider or third party administrator directly for information on their appeals procedure. Of course, the representative at MedExpert will also assist you if you have questions or need information. You can contact the MedExpert representative at (800) 999-1999.

You can contact the United States Department of Labor to seek assistance regarding your rights as provided by the Health Insurance Portability and Accountability Act (HIPAA), or other federal laws. The office to contact is as follows:

United States Department of Labor
Employee Benefits Security Administration
1055 East Colorado Boulevard, Suite 200
Pasadena, CA 91106
(626) 229-1000

17.4 Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act includes important protections for mothers and their children with regard to the length of the hospital stay following childbirth.

Health plans are required to provide coverage for a minimum of a 48-hour stay for the mother and newborn following a vaginal delivery and for at least a 96-hour maternity stay following a delivery by cesarean section. Under this law, a mother and newborn can leave prior to the end of the required minimum stay, provided there is a mutual agreement between the mother and doctor. The Anthem Blue Cross PPO Plan and each of the HMO medical plans under this Plan administer maternity benefits in accordance with the requirements of this Act.

If you have any questions, contact Anthem Blue Cross PPO, your HMO plan directly or MedExpert for assistance.

17.5 Women's Health and Cancer Rights Act (WHCRA)

The Women's Health and Cancer Rights Act (WHCRA) is a federal law requiring group health plans (HMOs and other insurers) providing coverage for mastectomies to also cover reconstructive surgery after a mastectomy in a manner determined in consultation with the attending physician and the patient. Prior to this law, the HMO plans generally already covered the services now mandated by this law. The purpose of this section is to remind you and your covered spouse of the following:

Under WHCRA, group health plans and health insurance issuers that provide medical and surgical benefits with respect to a mastectomy must, in the case of a covered individual who is receiving benefits in connection with a mastectomy, also provide coverage for mastectomy-related services including:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications in all stages of the mastectomy, including lymph edemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that are consistent with those established for other benefits under the plan or coverage.

If you have any questions, contact Anthem Blue Cross PPO, your HMO plan directly or MedExpert for assistance.

17.6 Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order issued by a court (or through a state administrative process) usually in a divorce case, that requires a group health plan to provide coverage to a child of a Participant, and which meets certain legal requirements. As required by law, the trust fund will provide benefits under such a Medical Child Support Order (MCSO) if it is “qualified.”

A QMCSO recognizes a child's right to receive trust fund benefits, as a beneficiary of an eligible trust fund Participant. The child, to be covered by the benefits of this Plan, must meet the age requirement and definition of eligible Dependent as defined previously under Article 4.10: Eligible Dependents on page 21.

Below are outlined the steps which will be followed in order to establish and determine the qualified status of a MCSO.

- 1) You must provide the Administrative Office with a copy of your Court ordered MCSO.
- 2) Within thirty (30) days after receipt of the MCSO, the Administrative Office will notify you and the eligible Dependent (through his or her custodial parent, guardian or representative), in writing, if the MCSO is “qualified.” If the order is “qualified” and hence a QMCSO, the Plan will provide information on enrolling the child in the Plan.
- 3) If the Plan determines that the Court order does not constitute a QMCSO, or additional information is required, you and the eligible Dependent (through his or her custodial parent, guardian or representative) will be notified in writing by the Plan.
 - a) If the Plan determines that the MCSO is not “qualified,” the notice shall describe the reasons for this decision. You have a right to appeal a denial, and the Plan's appeals procedures will be included along with the notice of denial.

- b) If additional information is required, you will be notified as to what is needed, and will have sixty (60) days to respond. If you do not respond within sixty (60) days, your request to cover a child under the terms of the MCSO will be deemed canceled.

17.7 Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) expanded the requirements initially provided under the Mental Health Parity Act (MPHA) that group trust funds and insurers provide equivalent benefits for mental health and substance disorder benefits.

For this Plan the effective date of the MHPAEA is July 1, 2011. It is the intention of the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund and the contracted insurers (Anthem Blue Cross, Kaiser Permanente and UnitedHealthcare) that the Plan's benefits be provided in full compliance with requirements of the MHPAEA as of July 1, 2011.

Please refer to the Evidence of Coverage documents provided to you by Anthem Blue Cross, Kaiser Permanente or by UnitedHealthcare for a complete description of the mental health and substance disorder benefits available to you under the terms of the Plan through these respective insurers. If you need further assistance or have questions you can always contact the Southern California IBEW-NECA Health Trust Fund Administrative Office or the website at www.scibew-neca.org.

17.8 Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") was enacted by Congress to provide protections to individuals who are eligible individuals of the "Uniformed Services." "Uniformed Services" is defined as the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the commissioned corps of the Public Health Services, and any other category of persons designated by the President in time of war or national emergency.

A. Military Leaves of Absence for a Period Less Than 31 Days

USERRA provides that if an Employee is on a military leave of absence from his employment, and the period of military leave is less than 31 days, he will continue to be eligible for health care coverage under this Plan during the leave with no self-payment required, provided he is eligible for benefits under this Plan at the time his military leave begins.

B. Military Leaves of Absence for Period More Than 30 Days

1. If an Employee is on a military leave of absence from his employment, and the period of military leave is more than 30 days, USERRA permits the Employee to continue coverage for himself and his Dependents at his own expense at a cost of 102% for up to 24 months so long as he gives the Administrative Office advance notice (with certain exceptions) of the leave, and so long as his total leave when added to any prior periods of leave does not exceed five (5) years.

2. The maximum period of continuation coverage for health care under USERRA is the lesser of:
 - a. 24 months (beginning from the date the Employee leaves work due to military leave);
or
 - b. The day after the date the Employee fails to timely apply or return to a position of employment with an Employer participating in the Plan.

C. Release from Active Service

Upon release from active service, the Employee's coverage will be reinstated on the day he returns to work or registers for dispatch with IBEW Local Union 11 as if he had not taken leave, provided he is eligible for re-employment under the terms of USERRA and provided he returns to work within:

1. One hundred and twenty (120) days from the date of discharge if the period of service was 31 days or more;
2. At the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight (8) hours) if the period of service was less than 31 days;
3. If the Employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended for up to two (2) years.

A copy of the Employee's separation papers must be submitted to the Administrator Office to establish his period of service.

D. Continuation of Coverage Under USERRA

If the Employee continues coverage under USERRA, he will be required to submit any required self-payment necessary, which may include Plan Administrative costs. If the Employee does not elect to continue coverage during his military leave, upon his return to work his coverage he will be reinstated at the same benefit level immediately preceding his service before his leave if he is eligible for re-employment under the criteria established under USERRA.

E. COBRA Continuation Coverage

If the Employee does not return to work at the end of his military leave, he may be entitled to purchase COBRA continuation coverage as provided in the section above. Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the Uniformed Services. The Uniformed Services and the Department of Veterans Affairs will provide care for service-connected injuries or illness.

The rights to self-pay are governed by the same conditions described in the COBRA section of this Summary Plan Description. If election is made for continuation coverage under USERRA, the COBRA and USERRA coverage periods will run concurrently.

Notwithstanding the foregoing, the Board of Trustees has adopted the following extraordinary USERRA benefit as outlined below. The Trustees in their sole discretion may eliminate the extraordinary benefit with a 60-day notice of same to Plan Participants.

1. Benefits as contained in this Summary Plan Description as of September 1, 2017, as amended from time to time, will be continued for Participants and their eligible Dependents for a period not to exceed five (5) years.
2. USERRA coverage will be provided at no cost to the Participant or his eligible Dependents.
3. Upon cessation of active employment and entitlement to coverage under USERRA, a Participant's Hours Bank Reserve will be frozen. The Hours Bank Reserve will be reinstated for the Participant on the day he returns to work or registers for dispatch with IBEW Local Union 11.

This extraordinary benefit will terminate for Employees and their eligible Dependents at the end of the Employee's military leave. At the end of the military leave, the above sections (Section B(2): Military Leaves of Absence for Period More Than 30 Days, Section C: Release from Active Service or Section E: COBRA Continuation Coverage) will apply as appropriate.

Article 18: Disclosure Information

18.1 As Required by the Employee Retirement Income Security Act of 1974 (ERISA)

A. Name and type of administration of the trust fund:

The name of the trust fund is the Southern California IBEW-NECA Health Trust Fund. The Trust Fund is administered by the Board of Trustees of the Southern California IBEW-NECA Health Trust Fund, a collectively bargained, jointly-trusted labor-management Trust Fund.

B. Name and address of the person designated as agent for the service of legal process:

Joanne M. Keller, CEO/Administrator
Thomas Schaefer, Assistant Administrator
6023 Garfield Avenue
Commerce, CA 90040
(Service of legal process may also be made upon any Trustee)

C. Administrative Office of the Plan Administrator:

6023 Garfield Avenue
Commerce, CA 90040
Administrator: Joanne M. Keller
Assistant Administrator: Thomas Schaefer

D. Names, titles, and addresses of the Trustees:

Labor Trustees (IBEW Local #11)

Marvin Kropke, Chairman
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Eric Brown
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Dick Reed
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Management Trustees (NECA)

James M. Willson, Secretary
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Cathy O'Bryant
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Shelley Keltner
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Kevin Norton, Alternate
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

Jeff Davis, Alternate
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

David Nott, Alternate
c/o Administrative Office
6023 Garfield Avenue
Commerce, CA 90040

E. Source of financing of the Plan and identity of any of the organizations through which benefits are provided:

Payments are made to the Plan by individual Employers under the provision of the applicable Collective Bargaining Agreements.

The Trustees provide a choice of hospital/medical programs.

The following organizations provide benefits by virtue of contracts with the Board of Trustees as follows:

- Anthem Blue Cross of California – PPO Hospital/Medical Benefits
- Kaiser Foundation Inc. – HMO Hospital/Medical Benefits
- UnitedHealthcare of California – HMO Hospital/Medical Benefits
- Citizens Rx – Self-Funded Prescription Drug Benefits
- CIGNA – DHMO Dental Benefits
- Delta Dental (PMI Dental) – DHMO Dental Benefits
- United Concordia – PPO AND DHMO Dental Benefits
- Vision Service Plan – Vision Benefits
- Anthem Blue Cross Life and Health Insurance Company – Life Insurance/AD&D benefits
- Optum, the health services division of UnitedHealth Group – Member Assistance Program (MAP)
- MedExpert – Advocacy and Assistance Services
- Body Scan International (BSI) – Medical Body Scans

F. Date of the end of the Plan year

June 30

G. Internal Revenue Service Plan Identification Number

95-6140101

H. A description of the relevant provisions of any applicable collective bargaining agreement:

The Plan is maintained pursuant to Collective Bargaining Agreements between Local #11 of the International Brotherhood of Electrical Workers, AFL-CIO and the L.A. County Chapter of the National Electrical Contractors Association. Copies of Collective Bargaining Agreements may be obtained by Plan participants from the Union or Administrative Office without charge upon written request. Additionally, Collective Bargaining Agreements may be examined by Plan participants at the Administrative Office of the Plan during regular business hours.

18.2 Claims and Appeal Rules

Remedies available under the Plan for the redress of claims, which are denied in whole or in part, including provisions required by Section 503 of Employee Retirement Income Security Act of 1974:

A. Introduction

Benefits provided to eligible Participants and Dependents by the following providers are subject to the claims and appeal rules established by these providers:

1. Kaiser HMO Medical Plan (including the Kaiser vision benefit)
2. UnitedHealthcare HMO Medical Plan
3. The Anthem Blue Cross Premier PPO Plan
4. Citizens Rx (Self-Funded Prescription Drug benefits)
5. United Concordia PPO Plan
6. CIGNA DHMO Dental Plan
7. Delta Dental DHMO (PMI Dental Plan)
8. United Concordia DHMO and PPO Dental Plans
9. Anthem Blue Cross Life and Health Insurance Company (Life Insurance/AD&D benefit)
10. Optum (Member Assistance Program)

11. MedExpert (Advocacy and Assistance Program)

12. Coast Benefits, Inc. (Medical Body Scan benefit, Specialized Footwear benefit and Health Reimbursement Arrangement benefit)

You should review each program's Evidence of Coverage document and contact the provider directly for its claims review or grievance procedure. The Administrative Office can provide you with information on where to write.

It is the intent and desire of the Trustees that these rules be consistent and comply with applicable regulations, including but not limited to 29 CFR 2560. et. seq. Please consult with each of the providers listed at their Evidence of Coverage on filing claims and appeals. These rules shall be construed in accord with that intent. Those regulations are incorporated here as though set forth in full. The regulations shall be construed in accord with Department of Labor guidance issued subsequent to issuance of the regulations.

B. Eligibility Determinations

The Administrative Office is responsible for determining eligibility. Each month the Administrative Office provides a listing of eligible participants to the benefit providers (Kaiser, UnitedHealthcare, Anthem Blue Cross, etc.).

There may be instances where a Participant has a claim denied because he or she has not met the plan rules to be eligible for benefits under the Plan. There are many reasons why this can happen.

For illustrative purposes only, several examples are cited below.

Example 1: A Participant may not work the required hours to be eligible for benefits as explained in Article 4: Eligibility and General Plan Provisions of this Summary Plan Description.

Example 2: A Participant has worked the required hours in covered employment but his or her employer has not remitted the required Contributions to the plan.

Example 3: A Participant does not work the required 100 hours per month to maintain eligibility and his or her Hours Bank Reserve has been depleted to zero, or there are not enough hours left in the Hours Bank Reserve to establish eligibility.

Example 4: A Participant is no longer working and the Participant has elected COBRA continuation coverage, but he or she has failed to make the required self-payment to be eligible for continuation coverage.

Most eligibility issues are resolved quickly with a call or a letter to the Administrative Office. The Administrative Office is there to assist you and provide you with exact information on the status of your eligibility and entitlement to benefits under the various plans.

C. Eligibility Appeals

If you have a claim denied because you do not meet the eligibility requirements of the Plan you have the right to appeal this denial. Your appeal must be in writing, and must be filed with the Administrative Office of the Trust Fund no later than 180 days after the denial of eligibility.

Regarding the timing of your appeal, please consider that the Trust Fund's benefit providers will generally not accept retroactive premiums or provide retroactive benefits beyond a typical 60- or 90-day time frame. As such, Participants and Dependents should, if possible, attempt to bring their appeal while considering those time frames.

When submitting an appeal, you must state in your appeal why you believe you meet the eligibility requirements (refer to Article 4: Eligibility and General Plan Provisions on page 13), and provide any factual information and evidence you believe is important in having your appeal reviewed.

The Trust Fund's Board of Trustees has established an Appeal Subcommittee for dealing with all eligibility appeals. The Appeal Subcommittee makes findings and recommendations to the full Board of Trustees which may be adopted by the Board of Trustees through the written unanimous consent provisions of the Trust Agreement.

D. Urgent and Pre-Service Claims

When an eligibility issue is intertwined with an urgent or pre-service claim, the Appeal Subcommittee will attempt to act through the written unanimous consent provisions of the Trust Agreement, subject to the 72-hour and 15-day requirements for urgent and pre-service claims, respectively.

E. Post Service Claims

When an eligibility issue affects a post-service claim, if the findings and recommendations of the Appeal Subcommittee are not adopted through the unanimous written consent procedure, the matter will be considered at the next regularly scheduled meeting of the Board of Trustees, subject to the 30-day requirement for post-service claims.

F. Exhaustion of the Appeal Process

Under a federal law known as ERISA, a Participant or Dependent whose claim for benefits has been denied may file suit against the Trust Fund seeking the denied benefit. However, prior to filing such a suit the appeal process under the Trust Fund described above must be pursued and exhausted. Thus, following any initial denial of benefits, if you disagree it is important you file a timely appeal. In all cases your appeal must be filed no later than 180 days after the initial denial of your claim was received by you. If you do not file an appeal within the required time frame you will have failed to exhaust your appeal rights. The organization responsible for hearing your appeal may extend the 180-day limit upon your showing good cause for the delay, but to protect your rights you should file any appeal promptly after your receipt of the initial denial.

Following the Trustees' decision, the Participant or Dependent shall have the right to bring a civil action under Section 502 of ERISA.

G. Some Questions Common to all Claims and Appeals Relating to Eligibility

Question: Who may file an appeal if my eligibility or the eligibility of my eligible dependents is denied?

Answer: You may file the appeal yourself or you may authorize a representative (i.e., doctor, spouse, etc.) to file an appeal on your behalf. Any representative acting on your behalf must have received written authorization from you to act on your behalf and that written authorization must be filed immediately with the Administrative Office as part of your appeal. If you are physically or mentally incapacitated the Trustees may waive this written authorization requirement. It is extremely important to understand that an assignment of benefits to the provider of services does not constitute an authorization for the provider to act as your representative.

Question: If my eligibility is denied will the Plan, upon request, supply me or my representative with all documents relevant to my eligibility claim?

Answer: Yes. You should be supplied copies of all documents and opinions relevant to your claim in accord with federal regulations.

H. Regulations

In conducting and considering all eligibility appeals, the Trustees intend to comply at all times with all applicable Department of Labor regulations, including 29 CFR Section 2560.530, as it may be amended from time to time. That regulation is incorporated herein by reference and is available to participants upon request.

18.3 Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

As a Participant in the Southern California IBEW-NECA Health Trust Fund, 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:

A. Receive Information About Your Plan and Benefits

- Examine, without charge, at the Administrative Office and at other specified locations, such as work locations and union halls, all documents governing the Plan, including summary plan descriptions, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series).
- Obtain, upon written request to the Administrative Office, copies of documents governing the operation of the Trust Fund, including collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan

description. The Trust Fund Administrative Office may make a reasonable charge for the copies.

- Receive a summary of the Trust Fund’s annual financial report. The Trustees are required by law to furnish each participant with a copy of this summary annual report.

B. Continue Group Plan Coverage

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a “qualifying event.” You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

C. Prudent Actions by Plan Fiduciaries

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

D. Enforce Your Rights

- If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits that is denied or ignored in whole or in part, and you have exhausted the claim review and appeal procedures available to you 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, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the

court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. Assistance with Your Questions

- If you have any questions about your Plan, you should contact the Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrative Office, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W., Suite N-5623
Washington D.C, 20210
Telephone: (202) 693-8680

- The nearest office of the Employee Benefits Security Administration is located at:

Los Angeles Regional Office
1055 E. Colorado Blvd, Suite 200
Pasadena, CA 91106.
Telephone: (626) 229-1000

- You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

18.4 Notice to Participants

A. Providers Regulated by the State of California

This applies to the following Providers under contract with the Trust Fund.

1. Kaiser HMO Medical Plan (including Kaiser vision benefit)
2. UnitedHealthcare HMO Medical Plan
3. The Anthem Blue Cross Premier PPO Plan
4. Citizens Rx (Self-Funded Prescription Drug benefits)
5. United Concordia PPO and DHMO Dental Plans
6. CIGNA DHMO Dental Plan
7. Delta Dental DHMO (PMI Dental Plan)

8. Anthem Blue Cross Life and Health Insurance Company (Life and AD&D benefits)
9. Vision Service Plan
10. Optum a health services division of UnitedHealth Group - Member Assistance Program (MAP)
11. MedExpert – Advocacy and Assistance Program

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number (888-466-2219) to receive complaints involving health insurance companies. If you have a grievance against the above-listed companies, you should contact the Provider and use the Provider's grievance process. If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the above-listed Provider, you may call the Department's toll-free number.

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