I. B. E. W. Local 332
Health and Welfare Plan

Dear Participant:

This booklet summarizes the benefits offered by the I.B.E.W. Local 332 Health and Welfare Plan effective July 1, 2022

Eligible Active Employees may choose among the different medical programs offered by the Plan, the current options available are: 1) medical benefits paid directly by the Plan, or 2) benefits provided by the Kaiser Foundation Health Plan. You may change the medical program covering yourself and your eligible family members during the annual open enrollment period, which will occur between November 1 and December 31. Provided your change request is received within the time allowed, your medical coverage selection will become effective on January 1. The Plan also provides dental, vision care, short-term disability, life insurance, and accidental death and dismemberment benefits. Effective June 1, 2016, the Plan offers a Health Reimbursement Arrangement (HRA) that can be used to reimburse out of pocket expenses for certain medical care expenses.

Except for short-term disability, life insurance, and accidental death and dismemberment benefits, Plan benefits are payable only for non-occupational illnesses and injuries. Occupational medical expense means any medical expense which arises out of or occurs in the course of any occupation or employment for wage or profit. If a claim for occupational illness or injury is denied by a worker's compensation insurer, you should submit the claim and a copy of your claim denial to the Plan Administrator's Office for consideration.

You do not have a vested right to benefits provided under this Plan. This means that benefits may be modified, reduced or eliminated in the future and any such change will apply to charges incurred for services or supplies on or after the effective date of the modification, reduction or elimination. This also means that benefits will not be paid to you for charges incurred after you terminate your participation in the Plan.

The Trustees of the Plan hope that these benefits will protect you and your family members if any of you suffer illness or injury. They also hope that you will use your health benefits intelligently, taking advantage of the in-network provider discounts and following the rules requiring pre-authorization of hospital stays and other cost containment features. By doing so, you will qualify for maximum benefits. At the same time, you will help the Plan to provide benefits in the most cost-effective way possible.

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

Only the full Board of Trustees is authorized to interpret the Plan. The Board has discretion to decide all questions about the Plan, including questions about your eligibility for benefits and the amount of any benefits payable to you. No individual Trustee, employer, union representative or employee of the Plan Administrator has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board. The Board also has discretion to make any factual determinations concerning your claim.

The Board of Trustees has authorized the Plan Administrator's Office to respond in writing to your written or oral questions. If you have an important question about your benefits, you should write to the Plan Administrator's Office for a definitive answer.

As a courtesy to you, the Plan Administrator's Office also may respond informally to oral questions. However, oral information and answers are not binding upon the Board of Trustees and cannot be relied on in any dispute concerning your benefits.

Plan rules and benefits may change from time to time. If this occurs, you will receive a written notice explaining the change. You may also receive updates for this booklet. Please be sure to read all Plan communications and keep any updates you receive with your booklet.

HELP PREVENT WASTE AND FRAUD

Every year billions of health care dollars are wasted because of erroneous and even fraudulent claims. Billing errors by hospitals and doctors' offices are very common. A few dishonest providers intentionally make false statements on bills or claim forms, or omit important information which would cause the claim to be denied.

You and your family can help catch billing errors and prevent fraud. Carefully review your bills and the Plan's written explanation of each benefit payment, and immediately report any errors or discrepancies. Respond promptly if the Plan Administrator requests your help to verify that a claim is valid. Do not give details about your health coverage to anyone except your authorized health care providers. Do not sign blank claim forms. Inform the Plan if outsiders attempt to obtain billing information or claim forms from you.

Your Plan takes fraud very seriously. All claims are checked to ensure the patient is eligible and the treatment was received. The Trustees require a full refund of any benefit payment obtained by fraud, with interest and legal costs. Any incident involving fraud also may be referred to the authorities for criminal prosecution. Any attempt to defraud a health plan is a crime under both Federal and state laws, even if the fraud is detected and the plan is not actually harmed. Concealment or omission of material information, such as a divorce or accurate marital status, is considered a false statement covered by this rule.

If you observe any activities by health care providers or others which might indicate fraud, please alert the Plan Administrator's Office immediately. The Plan will investigate the matter and take whatever action is necessary. If you wish, your report can be entirely confidential.

Make sure to update the Plan on any changes that may affect the eligibility of you or your dependents, including marriage, death, birth, divorce, or legal separation. If you fail to provide necessary information and the Plan provides coverage for an individual who is not eligible you may be held liable for the cost of the coverage, including any claims that were paid.

Remember to notify the Plan Administrator's Office if you change your address.

Sincerely,

THE BOARD OF TRUSTEES

If your claim for benefits is denied by the Board of Trustees, you may file a civil action under ERISA Section 502(a). No lawsuit may be filed without exhausting the Plan's review procedure. In any such lawsuit, the decision of the Board of Trustees will be subject to judicial review only for abuse of discretion. **No legal action may be commenced or maintained against the Trust or Plan more than two (2) years after the claim has been denied. Any legal action must be brought in the United States District Court for the Northern District of California.**

By participating in the Plan you and your dependents waive, to the fullest extent permitted by law, whether or not in court, any right to commence, be a party in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy relating to the Plan, and you and your dependents agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

See the Plan's complete Claims and Appeals Procedure in the General Provisions section of this booklet, beginning on page **90**.

CONTACTS AND RESOURCES GUIDE **If you have questions or need more information, please refer to the following telephone numbers and websites:**	
ELIGIBILITY, PREMIUMS, RESERVE AMOUNTS AND BENEFIT INFORMATION BOOKLETS	United Administrative Services (Plan Administrator's Office) (408) 288-4433 1-800-541-8059
SELF-FUNDED MEDICAL AND DENTAL PLAN	**For questions about claim payment, claim forms and benefit information, call:** Plan Administrator's Office (408) 288-4400 1-800-541-8059
ANTHEM BLUE CROSS/MEDICAL PPO	www.anthem.com/ca **To locate a participating preferred provider physician, clinic or hospital, call:** (408) 288-4400 1-800-541-8059 (Refer to Group # 277786M001)
ANTHEM BLUE CROSS/DENTAL PPO	www.anthem.com/ca **To locate a participating preferred provider dentist, call:** (408) 288-4400 1-800-541-8059
KAISER PERMANENTE	www.kaiserpermanente.org **For questions about benefit information and ID Cards, call:** 1-800-464-4000 (Refer to Group # 780)
MAXORPLUS/PHARMACY BENEFIT MANAGER	www.maxorplus.com **For questions about your prescription drug benefits, call:** 1-800-687-8629

MXP PHARMACY/MAIL ORDER RX	www.maxorplus.com **For questions about your mail order prescription drug benefits, call:** 1-806-324-5500
VISION SERVICE PLAN (V.S.P.)	www.vsp.com **For questions about vision benefits and vision claims or to locate a participating Vision Plan Provider, call:** 1-800-877-7195
BEAT IT!	www.beatiteap.com **For questions about alcohol and substance abuse, call:** 1-800-828-3939

I.B.E.W. Local No. 332 Health and Welfare Plan
Updated July 1, 2022
TABLE OF CONTENTS

PAGE

ELIGIBILITY

Eligibility

You are eligible for benefit coverage if you are employed under the jurisdiction of the Union as a member of the bargaining unit, a working member of the firm or of the Union, or an Alumni Employee of the Santa Clara and San Benito Counties Building and Construction Trades Council and if sufficient contributions have been made in your name by participating employers.

Active Employees

You and your eligible Dependents will be covered on the first day of the second month following the last day of any month in which you have accumulated a reserve of $1,725, and if contributions have been made and received in your name for the hours you have worked for one or more participating employers. The amount of accumulated reserves required for coverage are subject to annual review by the Board of Trustees.

On the first day of the calendar month preceding each month for which you are covered, $1,725 is deducted from your reserve accumulation. The $1,725 deduction covers medical, life, accidental death and dismemberment, short-term disability and hospital, surgical, dental, and vision benefits. Your maximum accumulated reserve can be $20,700 (12 months), which would be after the monthly deduction.

You may use your reserve accumulation to extend coverage only while you are employed or available for employment by a participating employer. When you are not employed or available for work by a participating employer, your reserve accumulation will be frozen and you will not be entitled to use it until you resume work for a participating employer or become available for work for a participating employer. If your reserve accumulation remains frozen for twelve (12) consecutive months, it will be cancelled and if it is cancelled, you will not be eligible for benefit coverage until you have met the requirements for "New Employee Participants" set out below.

Notwithstanding the foregoing rules, you must use your reserve accumulation to provide extended coverage at the time you retire or if you are unable to work for a participating employer due to disability.

If you are an active employee and are beginning a period of military service in any of the Uniformed Services of the United States, and have provided notice to the Plan Administrator, you may elect one of the following options for coverage for you and your dependents:

(a) To have your Reserve Bank frozen as of the first date of the month following the commencement of active service, and to have all eligibility for you and your dependents terminate on the first day of that month; or
(b) To have your Reserve Bank frozen as of the first day of the month following the commencement of active service, and make Self-Payments to continue coverage for you and your dependents (see Military Service under Self-Payments); or
(c) To continue eligibility for you and your dependents from your Reserve Bank, until the Reserve Bank is exhausted, followed by Self-Payments to continue coverage for you and your dependents (see Military Service under Self-Payments).

If you fail to notify the Plan Administrator of your entry into military service or fail to make an election when offered, you shall be deemed to have elected option (a). If you elect option (a) or (b), your Reserve Bank will be frozen and you will not be entitled to use it until you resume work for a participating employer or become available for work for a participating employer. Upon completion of military service, you must notify the Plan Administrator. If your period of service was more than 30 days but less than 181 days, you have 14 days from completion of your service to notify the Plan

Administrator. If you period of service was 181 days or more, you have 90 days from completion of your service to notify the Plan Administrator. If you fail to timely notify the Plan Administrator of completion of military service, your Reserve Bank will be cancelled and you will not be eligible for benefit coverage until you have met the requirements for "New Employee Participants" as set out below.

After you exhaust your Reserve Bank, you may elect to pay for COBRA Continuation Coverage prior to enrolling in one of the Retiree plans (if you are eligible to participate in the Retiree Plan).

In the event you retire with a Reserve Bank and are eligible for the Pre-Funded Early Retiree Plan, you shall first exhaust your Reserve Bank prior to receiving the 60 months of free coverage under the Pre-Funded Early Retiree Plan. After you exhaust your Bank Reserve, you may elect to pay for COBRA Continuation Coverage prior to enrolling in the Pre-Funded Early Retiree Plan.

Upon the failure or refusal of any employer to make required contributions, the Trustees and/or a designated committee of Trustees shall have authority to pay or provide for the payment from the Trust for the cost of providing the benefits hereunder for a maximum of two (2) months to the eligible employees of such delinquent employer, but the Trustees shall not be obligated either to the employees or the employer to make or provide such payments and they shall incur no liability whatsoever, either individually or collectively, for their failure or refusal to do so. In the event such payments are made by the Trustees from the Trust on behalf of a delinquent employer, the Trust shall be reimbursed by the employer for such payments and the Trustees shall have the authority to enforce such right of reimbursement.

Notwithstanding the foregoing rules, in the event an apprentice enrolled in the apprenticeship program through the Santa Clara County Electrical Joint Apprentice Training Fund has a Reserve Bank with insufficient reserves to continue eligibility as a result of attending day school, and the apprentice would have reserves sufficient to continue eligibility if credited with contributions for the hours attending day school, the apprentice's Reserve Bank will be credited with contributions for the hours they were attending day school, up to a maximum of 40 hours per week. The Plan shall request documentation from the Santa Clara County Electrical Joint Apprentice Training Fund related to school attendance for the apprentice before crediting the contributions. The contributions will be credited for the work month the apprentice was in school.

Residual Credits

Employees with less than $1,725 and no credits for twelve (12) consecutive months shall forfeit the residual amount and thereafter establish eligibility as a new Employee.

New Employee Participants

First-time participants must have accumulated an initial reserve of $3,450 (2 months) before the monthly deduction for coverage can be made.

Your Dependents become eligible for coverage on the later of (1) your eligibility date or (2) the date you acquire your first Dependent.

Special Enrollment for Dependents

Eligible Dependents may be enrolled into the Plan if they lose eligibility under Medicaid or a State Sponsored Children's Health Insurance Plan and/ or upon becoming eligible for a special premium assistance subsidy under Medicaid or a State Sponsored Children's Health Insurance Plan. You must file your enrollment form with the Trust Fund Office within 60 days of your Eligible Dependent losing coverage under Medicaid or a State sponsored Children's Health Insurance Plan or within 60 days of your Eligible Dependent becoming eligible for premium assistance under Medicaid or a State Sponsored Children's Health Insurance Plan.

Eligibility Example

To become covered initially, you must accumulate $3,450 from one or more participating employers.

Qualifying Months and Coverage Months

If, after initially becoming covered, you have $1,725 on the last day of any of the qualifying months, you will be eligible for coverage in the corresponding months as shown in the chart below.

Qualifying Month	Coverage Month	Qualifying Month	Coverage Month
May	July	November	January
June	August	December	February
July	September	January	March
August	October	February	April
September	November	March	May
October	December	April	June

On the first day of the calendar month preceding the coverage month, you shall have $1,725 deducted from your reserve bank accumulation for one (1) month of coverage.

Eligibility Based on Reciprocal Contributions

Contributions earned under another collective bargaining agreement and paid to another health plan may be transferred to this Plan pursuant to a written reciprocity agreement provided that (1) you complete a reciprocity request form and submit it to the plan in the area where you are working; and (2)(i) you are a member of I.B.E.W. Local 332 and have either worked in its jurisdiction or been eligible under this plan at any time during the preceding six (6) years, or (ii) you are currently eligible under this plan and provide the Board of Trustees with satisfactory evidence that you reside permanently in this jurisdiction and intend to return to work for a contributing employer as soon as work is available. If work is available within the jurisdiction of I.B.E.W. Local 332, the Plan may notify you in writing that you must return to this area and make yourself available to work for a contributing employer. If you fail to return and sign the out of work list at I.B.E.W. Local 332 within the time allowed by such notice, the plan will cease to accept reciprocal contributions on your behalf.

There is usually a lag of at least 30 days before this Plan receives reciprocity contributions, which may result in an interruption in coverage and possibly a COBRA notice. Coverage months based on reciprocal contributions are determined in accordance with normal Plan rules. A delay in receiving reciprocal contributions therefore may result in retroactive coverage.

Category 2-Non-Bargaining Unit Participants

Contributing employers may include themselves and other non-bargaining Employees in their contributions to be covered under the Plan in accordance with the rules established by the Board of Trustees. Payment must be made monthly in advance. The monthly charge may be changed by the Board of Trustees depending upon the experience of the group. The employees of the Joint Apprenticeship & Training Council may also be included in this category.

Effective January 1, 2004, Category (2) participants are Employees of the contributing employer who are not in the bargaining group and work exclusively at a facility located in the Santa Clara Valley.

ELIGIBILITY

The Trustees will permit the participation of Category (2) personnel under the following rules and regulations:

1. Contributing employers under a Collective Bargaining Agreement with I.B.E.W. Local 332 and who are National Electrical Contractors Association (NECA) members permanently located in Santa Clara Valley may elect to cover their Employees not covered by the Collective Bargaining Agreement, but must cover all such Employees if there are less than 5 Employees in this Category. Employers with more than 5 Employees must cover 80% in this Category. For the purposes of this section, "Employee" does not include the spouse of an owner, unless the spouse is performing bargaining unit work.

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

3. Contributing employers not electing to cover their Category (2) Employees may only apply on each successive anniversary date of the Plan, which is January 1 of each year. All applications and payments must be in the Plan Administrator's Office by December 15th and, thereafter, the monthly charge for this group must be paid in advance each month at the Plan Administrator's Office. Acceptance of Category (2) payments is subject to Trustee audit in compliance with the foregoing.

4. Non-Bargaining Unit Employees do not have a reserve bank accumulation but are eligible for all benefits under the Active Plan except the Short Term Disability Benefit. The Retiree Plan is also available to eligible retired Non-Bargaining Unit Employees. Non-Bargaining Unit Employees are not eligible for the Pre-Funded Early Retiree Plan.

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

6. Employers electing to cover their Non-Bargaining Unit Employees must sign a written subscription agreement acknowledging the above rules and agreeing to be bound by the terms of the Trust Agreement for the I.B.E.W. Local 332 Health & Welfare Plan, and specifically to comply with Trust rules concerning compliance with payroll audits and assessment of liquidated damages and other costs if payments are not received on time.

7. Category 2 Employees will no longer be eligible for coverage if the employer becomes two or more months delinquent. Coverage will not be reinstated until the delinquency is cured (including interest, liquidated damages, attorney’s fees or costs owing on the principal amount) and reinstatement is approved by the Board of Trustees.

Dependent Eligibility

Please refer to the “Definition of Terms” section of this benefit booklet (page 104) for the definition of eligible dependents.

Termination of Coverage

Coverage for yourself and your eligible Dependents will terminate:

1. On the last day of any month in which you fail to maintain the minimum reserve dollar bank amount for benefit eligibility; or

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

3. On the last day of the calendar month in which you enter military service, unless you have elected to use your Reserve Bank to continue coverage for you and your dependents; or

4. On the date you become employed in the electrical industry for an employer that does not contribute to a health and welfare plan benefiting workers in the electrical industry under the terms of a collective bargaining agreement. All contributions credited to your individual reserve dollar bank will be forfeited to the general reserves of the Trust if you lose eligibility for this reason.

The coverage for a dependent will terminate on the last day of the month in which the Dependent ceases to be an eligible Dependent. Coverage for your spouse will automatically end on the date of your divorce or legal separation. Coverage for your domestic partner and his or her children will automatically end on the date of your dissolution of domestic partnership.

You may remove a Dependent child that is over the age of 18 one-time from the Plan if your child is enrolled in a different group health plan. You must make the request to remove the Dependent child in writing and provide proof of other group medical coverage. You may reenroll the child at a later date during open enrollment or a special enrollment period, so long as the child remains an eligible Dependent under the terms of the Plan and you complete any enrollment forms and submit any other documents that may be required by the Fund Office.

Termination of Coverage for Apprentices Terminated from Apprenticeship Program

If you are a Participant in the I.B.E.W. Local 332 Health and Welfare Plan as an apprentice and you are terminated from the apprenticeship program, then you may use your Reserve Bank for up to two (2) months of continuing eligibility following the month in which the I.B.E.W. Local 332 Health and Welfare Plan receives notice from the apprenticeship program of your termination. If you do not have sufficient amounts in your Reserve Bank to cover two (2) months of coverage, then your coverage will terminate at the exhaustion of your Reserve Bank. Coverage for your dependents will cease concurrently with your coverage. Upon termination of coverage, you may elect to pay for COBRA Continuation Coverage for you and your dependents.

One-Time Removal of Dependent Spouse

You may remove a dependent spouse one-time from the Plan if your dependent spouse is enrolled in a different group health plan. You must make the request to remove the dependent spouse in writing and provide proof of other group medical coverage. You may reenroll the dependent spouse in accordance with the special enrollment provisions below at a later date provided that (a) the dependent spouse has had credible coverage under a group health plan and has had no lapse in coverage since last enrolled in this Plan, and (b) you complete any enrollment forms or any other documents that may be required by the Plan Administrator.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SELF-PAYMENT

COBRA CONTINUATION COVERAGE RIGHTS

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

Introduction

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

The I.B.E.W. Local 332 Health and Welfare Plan offers no greater COBRA rights than what the COBRA statute requires, and this section of the benefit booklet should be construed accordingly.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

What is COBRA Continuation Coverage?

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

If you are an Employee, you will become a qualified beneficiary if you will lose your coverage under this Plan or an insured plan because either one of the following qualifying events happen:

1. Your hours of employment are reduced; or

2. Your employment ends for any reason.

If you are the spouse of an Employee, you will become a qualified beneficiary if you will lose your coverage under this Plan or an insured plan because any of the following qualifying events happens:

1. Your spouse dies;

2. Your spouse's hours of employment are reduced;

3. Your spouse's employment ends for any reason;

4. Your spouse becomes entitled to Medicare (Part A, Part B, or both); or

5. You become divorced or legally separated from your spouse. If an Employee cancels coverage for his or her spouse in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse provides written notice to the Plan Administrator within sixty (60) days after the divorce or legal separation and can establish that the Employee canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA continuation coverage may be available for the period after the divorce or legal separation.

Your Dependent children will become qualified beneficiaries if they will lose coverage under this Plan or an insured plan because any of the following qualifying events happens:

1. The parent-Employee dies;

2. The parent-Employee's hours of employment are reduced;

3. The parent-Employee's employment ends for any reason;

4. The parent-Employee becomes entitled to Medicare (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

6. The child is no longer eligible for coverage because he or she no longer qualifies as a "Dependent child."

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to an Employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Notices and Elections of COBRA Continuation Coverage

Under this Plan, but not an insured plan, your spouse's coverage ends the day that a divorce or legal separation occurs (coverage is lost for the spouse only). Under this Plan and an insured Plan, a Dependent child's coverage ends on the last day of the month in which the Dependent child no longer qualifies as a Dependent.

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

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

I.B.E.W. Local 332
Health and Welfare Plan
c/o United Administrative Services
6800 Santa Teresa Blvd., Ste. 100
San Jose, CA 95119

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state the name of the Plan (I.B.E.W. Local 332 Health and Welfare Plan), the name and address of the Employee covered by the Plan and the names(s) and address(es) of the qualified beneficiary(ies) who will lose coverage due to a qualifying event. The notice must also state the qualifying event (divorce, legal separation or child who no longer qualifies as a Dependent) and the date the qualifying event happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

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

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

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

Benefits Available Under COBRA Continuation Coverage

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

How Long COBRA Continuation Coverage Lasts

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

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

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

Disability extension of 18-month period of continuation coverage.

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

Extension of 18-month period of continuation coverage due to second qualifying event.

If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is timely given to the Plan Administrator. This extension may be available to the spouse and any Dependent children receiving COBRA continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child no longer qualifies as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under this Plan or an insured plan had the first qualifying event not occurred. In all these cases, the spouse or Dependent child must make sure that the Plan Administrator is notified in writing of the second qualifying event within sixty (60) days of the second qualifying event. The spouse or Dependent child must follow the procedures

specified in the box above, entitled “Notice Procedures.” Your written notice must state the second qualifying event and the date it happened. If the second qualifying event is a divorce, your notice must include a copy of the divorce decree. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required sixty (60) day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

How Much Does Continuation Coverage Cost?

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

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

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

First Payment for COBRA continuation coverage.

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

Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under this Plan or an insured plan would have otherwise been terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Plan Administrator to confirm the correct amount of your first payment.

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

I.B.E.W. Local 332
Health and Welfare Plan
c/o United Administrative Services
6800 Santa Teresa Blvd., Ste. 100
San Jose, CA 95119

Monthly payments for COBRA continuation coverage.

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

Monthly payments for continuation coverage should be sent to:

I.B.E.W. Local 332
Health and Welfare Plan
c/o United Administrative Services
6800 Santa Teresa Blvd., Ste. 100
San Jose, CA 95119

Grace periods for monthly payments.

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

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

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

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

1. The premium is not paid on time.

2. After electing COBRA continuation coverage, you, your spouse, or Dependent child becomes enrolled in Medicare.

3. After electing COBRA continuation coverage, you, your spouse or Dependent child becomes covered under another group health plan (as an Employee or Dependent) that does not impose any pre-existing condition exclusion for a pre-existing condition. If the new group health plan has exclusions or limitations for pre-existing conditions, your COBRA continuation coverage will end after the exclusion or limitation period no longer applies. For example, after a six month waiting period, or under the federal law that requires portability of health care coverage (the Health Insurance Portability and Accountability Act of 1996), the pre-existing condition clause expires.

4. The I.B.E.W. Local 332 Health and Welfare Plan no longer provides group health coverage to any of its participants.

5. Your last employer no longer participates in the I.B.E.W. Local 332 Health and Welfare Plan and establishes one or more group health plans that covers a significant number of Employees who were formerly covered under the I.B.E.W. Local 332 Health and Welfare Plan or your last employer begins contributing to another multiemployer group health plan. In such a case, the new

employer plan or multiemployer group health plan must assume the I.B.E.W. Local 332 Health and Welfare Plan's COBRA continuation coverage obligation for you, your spouse and Dependent children.

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

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

Transfer Rights

If you are covered by an insured plan that covers a limited geographic area and relocate to another area where employers contributing to the I.B.E.W. Local 332 Health and Welfare Plan have an active workshop, you may be entitled to elect coverage available to other Employees working in that area. If you find yourself in this situation, call or write the Plan Administrator. Under no circumstances would such a transfer prolong your maximum COBRA continuation coverage.

More Information About Individuals Who May Be Qualified Beneficiaries

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

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

Alternate recipients under Qualified Medical Child Support Orders.

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

For More Information About COBRA Continuation Coverage

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

Keep the Plan Administrator Informed of Address Changes

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

United Administrative Services
6800 Santa Teresa Blvd., Ste. 100
San Jose, CA 95119
Phone: (408) 288-4400

SELF-PAYMENT AND FREE COVERAGE FOR CERTAIN DISABLED EMPLOYEES

Upon proper application and approval by the Board of Trustees, benefit coverage shall be extended to Employees who become disabled while covered under the Plan. Such coverage shall be extended without deduction from the Employee's reserve account for a period of twelve (12) months. The twelve (12) months are a lifetime maximum. The Employee may elect to use some or all of his/her accumulated reserve before commencing the twelve (12) month free extension.

An Employee shall be eligible for up to ten (10) additional months of free coverage if the following conditions are met: (1) the Employee had at least ten (10) years of continuous coverage under the Plan as of the date of disability, (2) the Employee has exhausted the twelve (12) month free extension and his/her reserve account, (3) the Employee has obtained a Social Security Disability Award, (4) the Employee is awaiting the effective date of Medicare coverage based on the Disability Award, and (5) the Employee elects coverage under an HMO during the first open enrollment following the commencement of this special extension. The additional period of free coverage ends on the date the Employee becomes covered by Medicare based on the Disability Award.

Employees who obtain disability retirement under the I.B.E.W. Local 332 Pension Plan and who also fulfill the minimum sixty (60) months of coverage requirement shall be eligible, after exhausting the maximum twelve (12) month free disability coverage and any individual reserve, to make self-payments under the plan for active Employees until age sixty-two (62), at which time the Employee may transfer to the Retiree Plan or an earlier date if approved for Medicare benefits and the sixty (60) month requirement has been fulfilled.

DEATH

Surviving covered Dependents will be allowed to continue coverage after the death of the disabled Employee for the same time period and with the same limitations as if the Employee were still living, provided that such period equals or exceeds the maximum allowed under the COBRA requirements.

If you die as a result of a non-occupational accident, health and welfare coverage for your eligible dependents may be extended for up to twelve months at no cost, upon approval by the Board of Trustees. Such extended coverage shall begin only after your reserve bank of dollars has been exhausted. The eligible dependent(s) must provide the Plan Administrator’s Office with a copy of your death certificate before extended coverage can begin.

PARTIAL SELF-PAYMENTS

An Employee may maintain coverage by making timely partial self-payments if he meets the requirements of this section. A partial self-payment is equal to the difference between the amount in the Employee’s Reserve Bank and the required monthly deduction. For an Employee to be eligible to make a partial self-payment, there must be no lapse in coverage, and the Employee must have had coverage in the month immediately preceding the month for which he makes the partial self-payment. The prior month’s coverage must not have been provided through COBRA self-payment. An Employee who does not make a partial self-payment when eligible shall not be eligible to make another self-payment until his Reserve Bank has sufficient funds to pay for a month of coverage. An Employee must meet one of the following rules to be eligible to make a self-payment:

1. Employed by a Contributing Employer; or

2. Available for immediate dispatch to a Contributing Employer by being registered on the I.B.E.W. Local 332 out-of-work list; or

3. Working for an employer contributing to another health and welfare plan that is a party to a reciprocity agreement with this Plan.

Months in which an Employee receives coverage through partial self-payment shall count toward the Employee's maximum COBRA continuation period. The Employee must make the required partial self-payment by the 10th day of the month for which he is self-paying the premium. Such payments shall be payable to the IBEW Local 332 Health and Welfare Plan and remitted to the Fund Administrator.

CERTIFICATE OF FORMER COVERAGE

If you or your Dependent(s) lose coverage under this Plan, you will be furnished with a certificate of former Plan coverage. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage ends. You may also request a certificate within 24 months after losing coverage.

MILITARY SERVICE

If your eligibility for coverage under the Plan terminates because of a period of military service, you may be entitled to continue coverage in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, and the regulations issued thereunder. If you are on military leave for less than thirty-one (31) days, your employer is required to pay for your medical coverage. If your eligibility under the Plan is terminated due to a period of military service, you have the following options:

1. If your Reserve Bank was frozen, you can continue coverage for you and your dependents during your military leave, up to 24 months, by making self-payments. Upon returning to employment with a participating employer or being placed on the IBEW Local 332 out of work list and being available for work, your Reserve Bank will be unfrozen and used to continue coverage for you and your dependents.
2. If your Reserve Bank is used to continue eligibility during your military leave, once exhausted, you may continue coverage for you and your dependents by making self-payments for up to 24 months. Upon returning to employment with a participating employer or being placed on the IBEW Local 332 out of work list and available for work, you may reinstate your eligibility by making self-payments until you have accumulated a Reserve Bank sufficient to continue eligibility, not to exceed 24 months. If you are employed by a participating employer or are placed on the IBEW Local 332 out of work list and available to work, you will receive up to two (2) months of coverage for you and your dependents at no cost.

Self-payments to continue coverage are equal to no more than 102% of the cost of coverage.

To exercise your rights under this section, upon completion of military service, you must notify the Plan Administrator. If your period of service was more than 30 days but less than 181 days, you have 14 days from completion of your service to notify the Plan Administrator. If your period of service was 181 days or more, you have 90 days from completion of your service to notify the Plan Administrator.

EXTENDED COVERAGE UNDER FAMILY AND MEDICAL LEAVE ACT

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

SELF-PAYMENT

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

1. Inpatient treatment;

2. Absence from work or school for three or more days with continuing treatment by a health care provider;

3. Continuing treatment by a health care provider for a condition that is incurable or serious enough to result in three (3) or more days of incapacity; or

4. Prenatal care.

Requests for FMLA leave must be directed to your employer; the health plan cannot determine whether or not you qualify. If a dispute arises between you and your employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments. If the dispute is resolved in your favor, the health plan will obtain the FMLA-required contributions from your employer and will refund the corresponding COBRA payments to you.

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

SUMMARY OF BENEFITS

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

ACTIVE EMPLOYEES ONLY

Group Term Life Insurance (24-Hour Coverage)..... $22,000

Accidental Death & Dismemberment Insurance (24-Hour Coverage).....$22,000

Additional Group Term Life Insurance (24-Hour Coverage) $28,000

Effective January 1, 1999, Additional Group Term Life Insurance is provided to Employees covered under the Active Employees Plan who have five (5) or more years of vested credit under the I.B.E.W. Local 332 Pension Plan Part A. Effective January 1, 2000, Additional Group Term Life Insurance is provided to Non-Bargaining Unit Employees who have five (5) or more consecutive years of coverage under the I.B.E.W. Local 332 Health and Welfare Plan. This Coverage will terminate upon the date of the Employee's or Non-Bargaining Unit Employee's Early or Normal Retirement. Effective July 25, 2002, the benefit level is reduced for Non-Bargaining Unit Employees over age 65 as follows:

Age	Percent of pre-age 65 benefit
65 – 69	50%
70 – 74	25%
75 – 79	15%
80 – 84	10%
85+	5%

Short-Term Disability Benefit Amount
1st thirteen weeks ..... $100 per week
2nd thirteen weeks ..... $150 per week

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

ACTIVE AND CATEGORY 2 EMPLOYEES AND DEPENDENTS
SELF-FUNDED PLAN COVERAGE

Hospital-Medical-Surgical Expenses	The Plan will pay 80% of Covered Charges for in-network providers each calendar year in excess of the $250 deductible amount for each eligible person.
Inpatient Hospital Room Limit	The average semi-private room charge made in the hospital where the eligible person is confined.
Out-of-Network Provider Services	The Plan will pay 60% of all Usual, Customary, and Reasonable Charges each calendar year in excess of the $250 deductible amount for each eligible person.

	If there are fewer than two in-network primary care physicians within a 30-mile radius of your primary residence, medical benefits (but not hospital charges) will be paid at 80% of Usual, Customary, and Reasonable Charges.
In-Network Out-of-Pocket Maximum	For services rendered by in-network providers the Plan has a $3,000 per individual and $6,000 per family out-of-pocket maximum. All deductibles, coinsurance and copayments are included in the in-network out-of-pocket maximum. Certain out-of-network services under the *No Surprises Act* are applied to the in-network out-of-pocket maximum. Prescription drug copayments and pediatric dental copayments are also included in the in-network out-of-pocket maximum. Once the out-of-pocket maximum has been met during the calendar year for services in-network, there will be no further out-of-pocket expenses for the individual or family during the remainder of the year.
Out-of-Network Out-of-Pocket Maximum	For services rendered out-of-network the Plan has a $6,000 per individual and $13,000 per family out-of-pocket maximum, this is the maximum out-of-pocket expense that the participant will pay each calendar year. Excluded benefits and out-of-network prescription drug copayments are not included in this out-of-pocket maximum. Certain out-of-network services under the *No Surprises Act* are applied to the in-network out-of-pocket maximum.
Deductible Amount	$250 for all accidents and sickness applied once each calendar year for each eligible person. Maximum per family is $750.
Supplemental Accident Benefit	$500.
Convalescent Care	One-half of the average semi-private room allowance for 120 days in a convalescent period.
Mental Health Benefits Outpatient Services	**For non-Emergency Services:** Eighty percent (80%) of the Covered Charges at in-network facilities in excess of the applicable annual deductible amount. Services at out-of-network facilities are limited to 60% of Usual, Customary, and Reasonable Charges **Emergency Services:** Mental health outpatient care that constitutes an Emergency Service for treatment of an Emergency Medical Condition shall be covered in accordance with the rules for Emergency Services for Treatment of an Emergency Medical Condition on page 32.
Mental Health Benefits	**For non-Emergency Admissions**: If you use an in-network Hospital, the Plan will pay eight percent (80%) of your Covered Charges until the in-network out-of-pocket maximum is satisfied. Then the Plan will pay 100% (instead of eighty percent (80%)) of Covered Charges for the remainder of the calendar year. You can locate an in-network Hospital by going to Anthem Blue Cross's website. Services at out-of-network facilities are limited to 60% of Usual, Customary, and Reasonable Charges in excess of the applicable annual deductible.

	For Emergency Admissions: Mental health inpatient care that constitutes an Emergency Service for treatment of an Emergency Medical Condition shall be covered in accordance with the rules for Emergency Services for Treatment of an Emergency Medical Condition on page 32.
Mental Health Benefits Residential Care Confinements	**For Non-Emergency Admissions**: Eighty percent (80%) of the Covered Charges at an in-network inpatient residential care facility in excess of the applicable deductible amount for each eligible Employee or Dependent Spouse or Child with an Axis I diagnosis (as defined in the Diagnostic and Statistical Manual of Mental Disorders). Services at out-of-network facilities are limited to 60% of Usual, Customary, and Reasonable Charges. **For Emergency Admissions**: Residential Care Confinements that constitute an Emergency Service for treatment for an Emergency Medical Condition shall be covered in accordance with the rules for Emergency Services for Treatment of an Emergency Medical Condition on page 32.
Substance Use Disorder Benefits Outpatient Services	**For non-Emergency Services:** Eighty percent (80%) of the Covered Charges at in-network provider or facility in excess of the applicable annual deductible amount. Services at out-of-network providers or facilities are limited to 60% of Usual, Customary, and Reasonable Charges. **Emergency Services:** Substance use disorder care that constitutes an Emergency Service for treatment of an Emergency Medical Condition shall be covered in accordance with the rules for Emergency Services for Treatment of an Emergency Medical Condition on page 32.
Substance Use Benefits Inpatient Services	**For non-Emergency Admissions**: If you use an in-network provider and Hospital, the Plan will pay eight percent (80%) of your Covered Charges until the in-network out-of-pocket maximum is satisfied. Then the Plan will pay 100% (instead of eighty percent (80%)) of Covered Charges for the remainder of the calendar year. You can locate an in-network provider and Hospital by going to Anthem Blue Cross's website or contacting Beat It!. Services at out-of-network providers and facilities are limited to 60% of Usual, Customary, and Reasonable Charges in excess of the applicable annual deductible. **For Emergency Admissions:** Substance use disorder care that constitutes an Emergency Service for treatment of an Emergency Medical Condition shall be covered in accordance with the rules for Emergency Services for Treatment of an Emergency Medical Condition on page 32.

All of the above medical benefits are self-funded and are paid directly from Trust assets.

As an alternative to the Self-Funded Medical benefits described above, you may elect medical coverage through Kaiser. Kaiser benefits are described in detail by Kaiser brochures, which are available to you, upon request, from the Plan Administrator at no additional cost.

DENTAL BENEFITS FOR ACTIVE AND CATEGORY 2 EMPLOYEES AND DEPENDENTS

The benefits for services at a preferred provider are covered by the Plan area as follows:

100% of contract rate for Class I Services Diagnostic/Preventive Services.

80% of contract rate for Class II Basic Services.

60% of contract rate for Class III Major Services.

60% of contract rate for Class IV Orthodontic Services.

Deductible Amount- $50 per person and $150 per family per year for Class II and III services.

Maximum Benefit - For Class I, II and III services there is no maximum benefit for dependent children under age 19. For eligible employees, eligible dependent spouses, and eligible dependent children 19 and over there is a $2,000 calendar year maximum for Class I, II, and III services. The maximum benefit for Class IV services is $2,000 per lifetime.

The Trustees may approve advancement of annual dental maximums up to (4) years, only if they determine in their sole discretion that the participant will suffer extreme detriment if the services are not rendered.

HEARING CARE BENEFITS

See Hearing Care Benefits Section, page 63.

VISION CARE BENEFITS

See Vision Care Benefits Section, page 58.

LIFE INSURANCE

GROUP TERM LIFE INSURANCE
(For Active and Category 2 Employees)

Those Employees who have selected either the regular self-funded plan or one of the other medical plan options offered by the Plan will receive a Group Term Life Insurance benefit in the amount of $22,000.

Effective January 1, 1999, there is an additional $28,000 of Group Term Life Insurance for those Employees covered under the Active Employees Plan who have five (5) or more years of vested service credit under the I.B.E.W. Local 332 Pension Plan Part A. Effective January 1, 2000, there is an additional $28,000 of Group Term Life Insurance for Non-Bargaining Unit Employees who have five (5) or more consecutive years of coverage under the I.B.E.W. Local 332 Health and Welfare Plan. This additional insurance coverage will terminate upon the date of the Employee's or Non-Bargaining Unit Employee's Early or Normal Retirement.

Reduction in Benefit Level for Non-Bargaining Unit Employees Over Age 65 (effective July 25, 2002):

Age	Percent of pre-age 65 benefit
65 – 69	50%
70 – 74	25%
75 – 79	15%
80 – 84	10%
85+	5%

When the Insurance Company receives proof through the Administrative Office that you have died while insured for this benefit, the Insurance Company will pay the full amount of Life Insurance. Payment will be made under the terms of the Beneficiary and Assignment Provisions.

Your beneficiary will receive the full amount of your life insurance if you should die from any cause. You may change your beneficiary at any time upon written request.

If you are married, you may not designate a beneficiary other than your spouse unless your spouse consents in writing, witnessed by a notary public, to the designation of another beneficiary. If you designate your spouse as your beneficiary, this designation will be automatically revoked if you divorce.

Payment may be received:

1. In a lump sum;

2. In a series of monthly installments; or

3. Partly in a lump sum and the balance in a series of monthly installments.

Your insurance will be continued without payment of the premium for thirty-one (31) days after you cease to be eligible for benefits under this Plan as an Active or Category 2 Employee, provided the master policy remains in force. If you are totally disabled, you may be eligible for the disability extension described below.

LIFE INSURANCE CONVERSION

When your Life Insurance terminates under the Group Policy because you cease to be eligible, you may obtain a personal policy of Life Insurance without evidence of insurability, subject to the provisions below.

Definition

Life Conversion Period is the 31-day period commencing on the date your Life Insurance under the Group Policy ceased.

Death During Life Conversion Period

If you die during the *life conversion period*, the amount of Life Insurance which you were entitled to convert to a personal policy will be paid under the Group Insurance Policy. This is in lieu of payment under a personal policy, whether or not application has been made for one.

The Personal Policy

1. Must be applied for and the first premium paid to the Insurance Company during the *life conversion period*;

2. Shall be in an amount chosen by you which is equal to or less than the amount of Life Insurance for which you were insured under the Group Insurance Policy;

3. Shall contain no disability or accidental death benefits;

4. Shall be in a form, other than term insurance, which the Insurance Company then customarily issues to a person of your age and subject to any minimum face amount requirements;

5. Shall require payment of premiums at the Insurance Company's current rates for: (a) the type and amount of the policy; (b) the class of risk which applies to you; and (c) your attained age on the effective date of the personal policy;

6. Shall be effective on its date of issue; such date shall not be earlier than the next day after the *life conversion period* ends.

EXTENSION OF YOUR LIFE INSURANCE WHILE TOTALLY DISABLED

An extension of Life Insurance without payment of premium (herein called extension) will be granted to you if (1) you become totally disabled before age 60 while insured for this benefit; and (2) proof of such disability is sent to the Insurance Company while the Policy is in force and within 12 months of the date the disability began.

If you have converted all or part of your Life Insurance, you shall have no right to an extension. You will regain such right if the converted policy is surrendered to the Insurance Company without claim other than return of the premiums paid.

Amount of Insurance During the Extension Period

The amount of your Life Insurance extended shall not exceed the amount in force just before the extension starts. Such amount will be reduced when, by the terms of the Policy, the amount would have been reduced if you were not disabled. The amount will not be reduced solely because you become disabled.

Proof of Disability

Proof of total disability must be furnished by you as often as reasonably required by the Insurance Company. The Insurance Company may also require you to take a physical exam while you are disabled; such exam would be at the Insurance Company's expense and by a doctor chosen by the Insurance Company. If the disability continues for more than two consecutive years, the Insurance Company will not ask for proof more than once each year thereafter. The two-year period begins on the date the Insurance Company receives first written proof of disability.

Date Extension Commences

The extension will commence on the later of: (1) the date on which you become totally disabled; or (2) the date on which premium payment on your behalf stops.

Date Extension Ceases

The extension will cease on the earliest of: (1) the date you attain age 70; (2) the date you cease to be totally disabled; (3) the date you fail to submit proof of disability; (4) the date you refuse to be examined by a doctor as required in Proof of Disability; or (5) the date on which this Group Insurance Policy terminates.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

(For Active and Category 2 Employees)

The Plan provides accidental death and dismemberment insurance benefits as follows:

1. Accidental Death Benefit Full Amount $22,000

   Benefits will be paid if a covered individual incurs any of the losses listed in the Table of Losses (Item 3 below), if

   a. The loss (i) results from an accidental bodily injury which occurred while the individual was covered, and (ii) was independent of all other causes;

   b. The accidental bodily injury is evidenced by a visible bruise or wound [except in the case of (i) internal injuries shown by autopsy, or (ii) drowning]; and

   c. The loss occurs no more than 90 days after the injury.

2. Exclusions

   No Accidental Death Benefits will be paid for any loss which results directly or indirectly, wholly or partially, from:

   a. Self-destruction or attempted self-destruction or intentionally self-inflicted injury, while sane or insane; or

   b. Insurrection, riot, or war; or

   c. The committing of, or the attempting to commit, an assault or felony; or

   d. Disease or disorder of the body or mind; or

   e. Medical or surgical treatment or diagnosis or preventive care; or

   f. Ptomaines or bacterial infection (except only in pyogenic infection occurring at the same time as, and as a result of, a visible accidental wound); or

   g. The voluntary or involuntary: i) taking of drugs (except drugs taken as prescribed by a doctor) or poison; or ii) inhaling of gas.

3. Table of Losses

In the Event of Loss of:	**The Amount Payable Will Be:**
Life	The Full Amount
Both Hands or Both Feet	The Full Amount
Sight of Both Eyes	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and Sight of One Eye	The Full Amount
One Foot and Sight of One Eye	The Full Amount
One Hand	One-Half The Full Amount
One Foot	One-Half The Full Amount
Sight of One Eye	One-Half The Full Amount

Thumb and Index Finger of Either Hand	One-Fourth The Full Amount

With respect to hands or feet, "loss" means permanent severance at or above the wrist or ankle joint. With respect to eyesight, "loss" means the entire and permanent loss of sight.

SHORT-TERM DISABILITY BENEFIT

FOR ACTIVE BARGAINING UNIT EMPLOYEES ONLY

This benefit is designed to partially replace a participating employee's lost wages while disabled. This benefit is paid from Trust Fund assets.

Establishing and Maintaining Eligibility

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

The disability occurrence must commence while Plan coverage is in force and while the Employee was working or signed on the out-of-work list and available for work for a contributing employer. A terminated Employee, who is not signed on the out-of-work list, is not eligible for this benefit.

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

Eligibility for Benefits

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

Definition of Disability

Total Disability is defined as the complete inability of the Employee to perform any and every duty of his or her occupation within the electrical industry as the result of an accidental bodily injury, sickness, mental illness, substance abuse or pregnancy for which the Employee is under the continuous care of a Physician. For purposes of certifying Total Disability a physician is defined as a doctor of medicine, osteopathy, psychology, or podiatry, a dentist, a chiropractor or a certified nurse practitioner practicing within the scope of his or her license.

Benefit Payable

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

SHORT-TERM DISABILITY BENEFIT

Amount of Benefit

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

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

Pregnancy

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

Termination of Eligibility

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

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

Application for STD Benefits

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

Exclusions and Limitations on STD Benefits

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

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

6. For any disability for which you perform light-duty work.
7. The Employee's Total Disability is the result of an accidental bodily injury or sickness which is, or appears to be, the responsibility of a third-party for which payment is or may be made by the third-party or by an insurance company on the third party's behalf.
8. The Employee's Total Disability is the result of war or any act of war (declared or undeclared, and any substantial armed conflict between organized forces of a military nature).
9. For any disability or days of disability caused by substance abuse:
    a. If you are not undergoing a covered course of treatment;
    b. Beyond the date the covered course of treatment is completed; or
    c. For which Medical Benefits are not payable by the Plan, including a course of treatment that is terminated before it is completed.
10. The Employee's disability is due to an intentional self-inflicted injury, while sane or insane.
11. For any period of disability when you are confined for any reason in a penal or correctional institution.
12. For any disability caused while committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot.
13. For any disability caused by an attempt to commit or by the commission of a crime or felony.
14. For any disability caused or contributed to by your being engaged in an illegal occupation.
15. For any condition that does not meet the Plan's definition of Total Disability and cannot be verified by an examination by a physician designated by the Trustees.
16. The date the STD plan or the Trust terminates. Note: An Employee who is Totally Disabled and receiving STD benefits at the time his or her employer ceases participating in the Trust will continue to do so up to the maximum time period so long as he or she remains Totally Disabled and is otherwise eligible for benefits.

Any payments made pursuant to a collective bargaining agreement while an Employee is Totally Disabled will not affect the Employee's right to receive STD benefits.

Right for Independent Medical Examination

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

Social Security (FICA) Tax Reporting

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

SELF-FUNDED MEDICAL BENEFITS

FOR ACTIVE AND CATEGORY 2 EMPLOYEES AND ELIGIBLE DEPENDENTS

HOSPITAL AND MEDICAL

Deductible

Deductible: Employee and Dependents	$250 per calendar year	An Annual deductible of $250 per person or a maximum of $750 per family unit will be charged for covered charges occurring during a calendar year.
Deductible: Family	$750 per calendar year	

A maximum of three times the individual deductible, no more than $250 of which may be satisfied by only one person, will be applied to the covered charges incurred by a family unit during a calendar year.

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

Maximum Out-of-Pocket Expense for Out-of-Network Services

The Plan provides a maximum annual out-of-pocket expenses for out-of-network services of $6,000 per person and $13,000 per family.

Excluded benefits and out-of-network prescription drug copayments are not included in the out-of-pocket maximum for out-of-network services. Out-of-network services covered under the *No Surprises Act* will be applied toward the in-network out-of-pocket maximum. Out-of-network services covered under the *No Surprises Act* are:

- You receive Emergency Services at an out-of-network facility (unless you received proper notice and consent to out-of-network billing rates for certain post-stabilization services as allowed under the *No Surprises Act*).
- You receive non-emergency services from an out-of-network provider at an in-network facility (unless you received proper notice and consent to out-of-network billing rates as allowed under the *No Surprises Act*).
- You receive out-of-network air ambulance services.

Out-of-Network Providers

After the annual deductible is paid, the Plan pays 60% of the Usual, Customary, and Reasonable charges for services provided by out-of-network providers until the Maximum Out-of-Pocket Expense for Out-of-Network Services is met.

If you visit an out-of-network provider or facility in the following situations, the out-of-network provider or facility may not balance bill. In addition, your cost-sharing will be the same as if you had visited an in-

network provider or facility, meaning that once you have met your deductible, your coinsurance costs will be applied to your in-network out-of-pocket maximum and coinsurance percentage will be the same as if you had visited an in-network provider or facility. Your coinsurance percentage will be applied to the lesser of the billed charge or the Qualifying Payment Amount.

- You receive Emergency Services at an out-of-network facility (unless you received proper notice and consent to out-of-network billing rates for certain post-stabilization services as allowed under the *No Surprises Act*).
- You receive non-emergency services from an out-of-network provider at an in-network facility (unless you received proper notice and consent to out-of-network billing rates as allowed under the *No Surprises Act*).
- You receive out-of-network air ambulance services.

A "visit" with respect to services at an in-network facility includes the furnishing of equipment and devices, telemedicine services, regardless of whether the provider furnishing such items or services is at the facility. These services are not limited based on whether the provider furnishing the services is physically located at the facility.

In-Network Out-of-Pocket Maximum

The Plan has an annual in-network out-of-pocket maximum of $3,000 per individual and $6,000 per family. Once you have reached your maximum out-of-pocket expenses for in-network services, the Plan will cover in-network services at 100%. All in-network deductibles and coinsurance and copayments are counted toward your in-network out-of-pocket maximum. The annual in-network out-of-pocket maximum does not include out-of-pocket expenses for non-covered services, balance-billing amounts, cost sharing for out-of-network provider services, vision and non-pediatric dental benefits. Out-of-network services covered under the *No Surprises Act* will be applied toward the in-network out-of-pocket maximum. Out-of-network services covered under the *No Surprises Act* are:

- You receive Emergency Services at an out-of-network facility (unless you received proper notice and consent to out-of-network billing rates for certain post-stabilization services as allowed under the *No Surprises Act*).
- You receive non-emergency services from an out-of-network provider at an in-network facility (unless you received proper notice and consent to out-of-network billing rates as allowed under the *No Surprises Act*).
- You receive out-of-network air ambulance services.

Prescription drug copayments will be counted toward your out-of-pocket maximum. However, if you request a brand-name drug when a generic is available, your out-of-pocket expenses, including your copayment, will not count toward your out-of-pocket maximum.

In-Network Providers

The Plan contracts with Anthem Blue Cross to obtain access to certain Preferred Provider Organization (PPO) providers. These are preferred facilities (hospitals, labs, emergency outpatient clinics, specialty facilities) and providers (physicians, specialists) who have agreed to accept a negotiated amount for various services provided to participants. By utilizing an in-network provider, you can reduce your out-of-pocket costs.

Finding an In-Network Provider / Facility

The Plan's PPO with Anthem Blue Cross offers the state's largest network of providers and facilities that have lower costs and pre-negotiated rates, and these savings pass on to you. On top of that, the Anthem Blue Cross "Prudent Buyer" PPO providers agree not to "balance bill" – i.e.,

charge you any more than the pre-negotiated fee. You won't receive this fee protection if you receive services from a provider or facility that is not part of the Anthem Blue Cross "Prudent Buyer" PPO network.

Anthem Blue Cross offers you quick and easy ways to find participating health care providers, including doctors and hospitals. To find a provider, simply go to the Anthem Blue Cross website and use their online provider finder resource. Go to **www.anthem.com/ca** and click on *Find Care.*

Anthem Blue Cross maintains a provider directory. Anthem Blue Cross updates its provider directory every ninety (90) days and will respond to inquiries about the network status of a provider or facility within one (1) business day. If you or your dependent receive inaccurate information from Anthem Blue Cross or the Plan's administrative office about a provider or facility's network status, you will only be liable for in-network coinsurance rates for the services underlying the inquiry. It is your responsibility to confirm that the provider or facility selected is in-network at the time you receive services.

UTILIZATION REVIEW PROGRAM

To receive maximum benefits for hospital and mental health services, you must obtain pre-authorization from Anthem Blue Cross by calling 1-800-274-7767.

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

1. **You are free to use any hospital or doctor when services are necessary. However, when you or your covered dependents receive services from an in-network provider, the charges are less and your out-of-pocket costs are less.**

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

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

4. **Non-emergency hospital admissions should have pre-admission authorization whether the planned admission is at an in-network or out-of-network hospital.** Please be sure that your physician's office remembers to telephone the Utilization Review office at 1-800-274-7767. For emergency admissions, the Review office should be notified within 24 hours.

The Process Is Simple

There are three simple steps to the inpatient program: (1) Pre-Admission Review, (2) Concurrent Review, and (3) Discharge Planning.

(1) Pre-Admission Review

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

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

- Nervous or mental disorders.
- What is the medical necessity for the admission?
- Are outpatient services more appropriate?
- Is a second surgical opinion required?
- What is the appropriate length of stay for this condition?

Although your doctor will generally get any required pre-authorization from Anthem Blue Cross, it is your responsibility to make sure that pre-authorization has been obtained from Anthem Blue Cross.

Emergency Services and Emergency hospital admissions do not require pre-authorization or pre-admission review. Anthem Blue Cross should be notified of an emergency hospitalization on the first business day following admission.

(2) Concurrent Review

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

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

(3) Discharge Planning

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

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

Appeals Process

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

UTILIZATION REVIEW
IT WORKS FOR YOU - WITH YOUR HELP!

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

ANTHEM BLUE CROSS UTILIZATION REVIEW
1-800-274-7767

Anthem Blue Cross PPO

HEALTH CARE INFORMATION AND ASSISTANCE

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

How It Works

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

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

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

All calls are handled confidentially.

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

Examples of Questions or Assistance

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

EMERGENCY SERVICES FOR TREATMENT OF AN EMERGENCY MEDICAL CONDITION

The Plan covers Emergency Services for treatment of an Emergency Medical Condition in compliance with the *No Surprises Act.*

For Emergency Services for treatment of an Emergency Medical Condition the Plan pays benefits at the following rates, without prior authorization and without regard to any other term or condition of the Plan or coverage other than the exclusion or coordination of benefits (to the extent not inconsistent with

benefits for Emergency Medical Condition), for Covered Charges in excess of any then-applicable deductible:

(1) In-Network Provider: 80% of the applicable Covered Charges counting the eligible participant or eligible dependent's cost-sharing amount toward the in-network out-of-pocket maximum; and

(2) Out-of-Network Provider or Out-of-Network Emergency Facility: If an eligible participant or eligible dependent receives Emergency Services for treatment of an Emergency Medical Condition from an out-of-network provider or out-of-network emergency facility, the eligible participant or eligible dependent will have the same coinsurance as for an in-network provider (20%after the applicable deductible) and the coinsurance will be applied to the lesser of billed charges or the Qualifying Payment Amount, counting the eligible participant's or eligible dependent's cost-sharing amount toward the in-network out-of-pocket maximum. Where the eligible participant or eligible dependent receives proper notice and consents to certain post-stabilization services being paid at the out-of-network rate as allowed by the *No Surprises Act*, the Plan pays 60% of the Usual, Customary, and Reasonable Charges and does not count the eligible participant's or eligible dependent's cost-sharing toward the in-network out-of-pocket maximum.

For purposes of this Section, the following terms mean:

(1) Qualifying Payment Amount means the Plan's median contracted rate for the item or service in the same geographic region, as adjusted under DOL Regulation 2590.716-6(c).

(2) Emergency Services means, with respect to an Emergency Medical Condition:
    a. An appropriate medical screening examination that is within the capability of an emergency room of a hospital or independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition;
    b. Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable (regardless of the department of the hospital in which such further examination or treatment is furnished); and
    c. Post-stabilization services furnished by out-of-network providers or out-of-network facilities as part of outpatient observation or an inpatient/outpatient stay related to the Emergency Medical Condition (regardless of the department of the hospital in which such further examination or treatment is furnished), until (1) the treating provider or facility determines that the individual is able to travel using non-medical transportation or non-emergency medical transportation; and (2) the individual is provided with appropriate written notice to consent to out-of-network treatment and gives informed consent to such out-of-network treatment.

(3) An Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the conditions described below:
    a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
    b. Serious impairment to bodily functions; or
    c. Serious dysfunction of any bodily organ or part.

Balance billing for Emergency Services for treatment of an Emergency Medical Condition is generally prohibited.

COVERED CHARGES

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

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

3. Intensive Nursing Care for each day of confinement in a hospital as follows:

   a. For those hospitals which make a separate charge for Intensive Nursing Care, the hospital's specific charge for Intensive Nursing Care is covered.

   b. For those hospitals which make a combined charge for Room and Board and Intensive Nursing Care, that part of the combined charge that is in excess of the hospital's prevailing semi-private Room and Board rate will be the covered charge for Intensive Nursing Care.

4. Anesthesia supplies and administration.

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

6. Usual, Customary and Reasonable Charges of a physician or surgeon for the performance of an operation, the repair of a dislocation or fracture, and for medical services. Charges of an assistant surgeon are also covered.

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

8. Services of a licensed physiotherapist.

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

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

11. X-ray, radium and radioactive isotope therapy.

12. Charges for the repair of sound natural teeth (including their replacement) required as a result of, and within 24 months of, an accidental bodily injury that occurs while the person is covered under the Plan.

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

    Medical transport by a rotary-wing or fixed wing ambulance will be covered in accordance with the *No Surprises Act*. The Plan will pay benefits at the following rates, for Covered Charges in excess of any then applicable deductible:

a. In-Network Provider: 80% of the applicable Covered Charges, counting the participant's or eligible dependent's coinsurance amount toward the in-network out-of-pocket maximum.
b. Out-of-Network Provider: The participant's or eligible dependent's coinsurance will be the same as for an in-network provider (20% after the applicable deductible) and the coinsurance amount will be determined using the lesser of billed charges or the Qualifying Payment Amount, counting the participant's or eligible dependent's coinsurance amount toward the in-network out-of-pocket maximum. The Qualifying Payment Amount means the Plan's median contracted rate for the item or service in the same geographic region, as adjusted under U.S. Department of Labor Regulation 2590.716(c).

Providers of air ambulance services are generally prohibited from balance billing eligible participants or eligible dependents.

14. Medical supplies as follows:

a. Drugs which require a written prescription from a doctor and must be dispensed by a licensed pharmacist or doctor.

b. Blood and other fluids to be injected into the circulatory system.

c. Artificial limbs and eyes for loss of natural limbs and eyes which occurred while coverage is in force.

d. Lens, each eye (contact or frames) immediately following and because of cataract surgery only.

e. Casts, splints, trusses, braces, crutches, and surgical dressings.

f. Purchase or rental of hospital-type equipment for kidney dialysis for your personal and exclusive use. The total purchase price considered will be on a monthly pro-rata basis during the first 24 months of ownership, but only so long as a dialysis treatment continues to be medically necessary. Also covered are all charges for supplies, materials and repairs necessary for the proper operation of such equipment and reasonable and necessary expenses for the training of a person to operate and maintain the equipment for your sole benefit. No benefits are paid on or after the day you are entitled to benefits under Medicare.

g. Rental (not to exceed the purchase price) or purchase (if the cost is less than the rental for the period required) of durable medical equipment such as oxygen, a wheelchair, or hospital bed for medically necessary therapeutic treatment of a covered illness or non-industrial injury, which is:

(1) Manufactured specifically for medical use, and of no further use when medical need ends;

(2) Usable only by the patient;

(3) Not primarily for the comfort or hygiene of the eligible individual, or solely to aid the caregiver;

(4) Not for environmental control;

(5) Not for exercise;

(6) Approved as effective and usual and customary treatment of a condition as determined by the Fund; and

(7) Not for prevention purposes.

15. Preventive Care Benefits:
All in-network preventive care is covered at no cost and is not subject to the Plan's deductible.

Preventive care includes, but is not limited to:

a. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009;
b. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
c. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Heath Resources and Services Administration (HRSA); and
d. With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines by HRSA, to the extent not included in certain recommendations of the USPSTF.

The Plan covers the following services, where appropriate, as preventive care:

Preventive Health Services for Adults

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol misuse screening and counseling
- Aspirin use to prevent cardiovascular disease and colorectal cancer for adults 50 to 59 years with a high cardiovascular risk
- Blood pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal cancer screening for adults 45 to 75
- Depression screening
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
- Diet counseling for adults at higher risk for chronic disease
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 yers and over, living in a community setting
- Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants with at least one parent born in a region with 8% or more Hepatitis B prevalence
- Hepatitis C screening for adults age 18 to 79 years
- HIV screening for everyone ages 15 to 65, and other ages at increased risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adults at high risk for getting HIV through sex or injection drug use
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
  Diphtheria
  Hepatitis A
  Hepatitis B
  Human Papillomavirus

Influenza (Flu Shot)
Measles
Meningococcal
Mumps
Pertussis
Pneumococcal
Rubella
Shingles
Tetanus
Varicella (Chickenpox)

- Lung cancer screening for adults 50 to 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
- Obesity screening and counseling
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk
- Syphilis screening for all adults at higher risk
- Tobacco use screening for all adults and cessation interventions for tobacco users
- Tuberculosis screening for certain adults without symptoms at high risk

Preventive Health Services for Women

- Bone density screening for all women over age 65 or women age 64 and younger that have gone through menopause
- Breast cancer genetic test counseling (BRCA) for women at higher risk
- Breast cancer mammography screenings
    - Every 2 years for women 50 and over
    - As recommended by a provider for women 40 to 49 or women at higher risk for breast cancer
- Breast cancer chemoprevention counseling for women at higher risk
- Breastfeeding support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women
- Birth control: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
- Cervical cancer screening – Pap test (also called Pap smear) for women age 21 to 65
- Chlamydia infection screening for younger women and other women at higher risk
- Diabetes screening for women with a history of gestational diabetes who aren't currently pregnant and who haven't been diagnosed with type 2 diabetes before
- Domestic and interpersonal violence screening and counseling for all women
- Folic acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 pregnant (or later) and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Maternal depression screening for mothers at well-baby visits
- Preeclampsia prevention and screening for pregnant women with high blood pressure
- HIV screening and counseling for everyone age 15 to 65 and other ages at increased risk
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative women at high risk for getting HIV through sex or injection drug use
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Sexually transmitted infections counseling for sexually active women
- Syphilis screening
- Tobacco use screening and interventions
- Expanded tobacco intervention and counseling for pregnant tobacco users

- Urinary incontinence screening for women yearly
- Urinary tract or other infection screening
- Well-woman visits to get recommended services for all women

Preventive Health Services For Children

- Alcohol, tobacco, and drug use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Bilirubin concentration screening for newborns
- Blood pressure screening for children: Age 0 to 11 months, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years
- Blood screening for newborns
- Depression screening for adolescents beginning routinely at age 12
- Developmental screening for children under age 3
- Dyslipidemia screening for all children once between 9 and 11 years and once between 17 and 21 years, and for children at higher risk of lipid disorders
- Fluoride supplements for children without fluoride in their water source
- Fluoride varnish for all infants and children as soon as teeth are present
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns; and regular screenings for children and adolescents as recommended by their provider
- Height, weight and body mass index measurements taken regularly for all children
- Hematocrit or Hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Hepatitis B screening for adolescents at high risk
- HIV screening for adolescents at higher risk
- Hypothyroidism screening for newborns
- PrEP (pre-exposure prophylaxis) HIV prevention medication for HIV-negative adolescents at high risk for getting HIV through sex or injection drug use
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
    - Diphtheria, Tetanus, Pertussis (DTaP)
    - Haemophilus influenzae type b
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus (HPV)
    - Inactivated Poliovirus
    - Influenza (Flu Shot)
    - Measles
    - Meningococcal
    - Mumps
    - Pneumococcal
    - Rubella
    - Rotavirus
    - Varicella (Chickenpox)
- Lead screening for children at risk of exposure
- Obesity screening and counseling
- Oral health risk assessment for young children from 6 months to 6 years
- Sexually transmitted infection (STI) prevention counseling and screening for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis: Age 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years
- Vision screening for all children.

- Well-baby and well-child visits

The list of in-network preventive services covered at 100% in-network with no deductible changes periodically. You can find an up-to-date list at https://www.healthcare.gov/coverage/preventive-care-benefits/.

NO BENEFIT IS PAID FOR OUT-OF-NETWORK PROVIDERS.

16. Immunizations:

    The Plan covers immunizations for both adults and children recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. No other immunizations are covered. There is no deductible for covered immunizations.

    For the duration of the COVID-19 public health emergency, the Plan will cover all Advisory Committee on Immunization Practices recommended COVID-19 vaccines and related administration charges at no cost, regardless of whether the vaccine is administered by an in-network or out-of-network provider. There is no deductible for COVID-19 vaccinations. If the vaccine is administered by an out-of-network provider, the Plan will reimburse the out-of-network provider a reasonable amount, determined in comparison to the prevailing market rates.

17. Maternity Care Expenses:

    Maternity care expenses are covered the same as any other illness and are provided for pregnancy care, childbirth and treatment of related conditions.
    Coverage must be in effect at the time of delivery.

    Hospital well baby nursery charges for babies born to Employees and their eligible spouses are covered only in in-network hospitals and only during the mother's normal maternity stay. Babies born to the eligible Dependent Children of an Employee are not eligible for coverage under this Plan.

    Newborn and Mothers Health Protection Act

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

18. Chiropractic and Acupuncture Treatment.

    CHIROPRACTIC AND ACUPUNCTURE BENEFITS

    After the calendar year deductible has been satisfied:
    - In-Network Provider Percentage– 80%
    - Out-of-Network Provider Percentage – 60%

Chiropractic Benefits

Benefits are provided for medically necessary chiropractic services for treatment of a non-occupational disease, illness or injury rendered by a licensed chiropractor (D.C.). The chiropractic benefit includes the initial and subsequent office visits, an initial examination, adjustments, conjunctive therapy, and x-ray services subject to a combined maximum of thirty (30) visits per calendar year.

Acupuncture Benefits

Benefits are provided for medically necessary acupuncture services for treatment of a non-occupational disease, illness or injury rendered by a physician (M.D. or D.O.). The acupuncture benefit includes the initial and subsequent office visits, an initial examination, treatment planning and evaluation, electroacupuncture, cupping and moxibustion subject to a combined maximum of thirty (30) visits per calendar year.

19. Chemical Dependency

    Inpatient or Outpatient treatment will be paid as indicated for self-funded plan participants.

20. Mental Health Benefits

    Nervous or mental disorders will be paid as indicated for self-funded plan participants.

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

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

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

    c. Prostheses.

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

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

22. The Plan provides coverage for Coronavirus/COVID-19 testing with no-cost sharing (copayments or deductible), prior authorization or other medical management requirements for both in-network providers and out-of-network providers. This includes the test, administration of the test, and the health care provider visit (office visit, telehealth visit, urgent care visit or emergency room visit) that results in an order for or administration of the test.

    In-network providers will be reimbursed at the negotiated rate. Out-of-network providers will be reimbursed in the amount equal to the cash price for such service as listed by the provider on a public internet website.

23. Telehealth Benefits

The Plan will cover telehealth visits. Telehealth visits include all remote provider services conducted via telephone, video or other online capability. This includes, but is not limited to, visits using Anthem's LiveHealth Online program, which provides access to medical care in minutes through phone and video consults.

While the Plan strongly encourages the use of in-network providers, for the duration of the Coronavirus pandemic, the Plan will cover both in-network provider and out-of-network provider telehealth visits without a copayment.

24. No Surprises Act

The Plan is compliant with the *No Surprises Act*, Title 1 of Division BB of the Consolidated Appropriations Act, 2021 (the "*No Surprises Act*"). To the extent any provision of this Plan is inconsistent with the *No Surprises Act*, the *No Surprises Act* shall govern. Notwithstanding any other provision of the Plan to the contrary, and subject to all applicable Plan Exclusions, Limitations & Non-Covered Charges, in accordance with the *No Surprises Act*, the Plan will apply the in-network coinsurance percentage to out-of-network Air Ambulance Services, Emergency Services for treatment of Emergency Medical Conditions by out-of-network providers and out-of-network emergency facilities (unless the eligible participant or eligible dependent received proper notice and consented to the out-of-network billing rates for certain post-stabilization services as allowed under the *No Surprises Act*), and non-emergency services from out-of-network providers at in-network facilities (unless the eligible participant or eligible dependent received proper notice and consented to the out-of-network billing rates as allowed under the *No Surprises Act)*. Notwithstanding any Plan provision to the contrary, for out-of-network services covered by the *No Surprises Act*, the in-network coinsurance percentage shall be applied to the lower of the billed charge or the Qualifying Payment Amount. The Qualifying Payment Amount means the Plan's median contracted rate for the item or service in the same geographic region, as adjusted under DOL Regulation 2590.716-6(c). There will be no balance billing for services covered by the *No Surprises Act*.

For services covered under the Plan and subject to the *No Surprises Act*, the Plan will pay the provider or facility, subject to all applicable Plan exclusions, limitations & non-covered charges, an agreed upon amount, and if there is no agreed upon amount, and amount determined by an Independent Dispute Resolution Entity in accordance with 9816(c) or 9817(b) of the Internal Revenue Code, Section 716(c) or 717(b) of ERISA, or Section 2799A-1(c) or 2799A-2(b) of the PHS Act.

25. Continuity of Care

Eligible participants and eligible dependents who are currently receiving treatment at a provider or facility for serious and complex conditions, course of institutional or inpatient care, scheduled nonelective surgery including post-operative care, course of treatment for pregnancy, or are terminally ill, and whose provider or facility has a change in their contractual relationship, (including, but not limited to, changing from an in-network provider/facility to an out-of-network provider/facility) may request to continue to have services provided under that current provider or facility under the same terms and conditions as if no contractual change had occurred. Upon notice to the eligible participant or eligible dependent of the change in contractual relationship, the eligible participant or eligible dependent may elect to continue are at that current provider or facility under the same terms and conditions as if no contractual change had occurred for 90 days from the receipt of the notice, or until the individual no longer qualifies for continuing care, whichever is earlier. Such continuity of care shall comply with Section 113 of the Consolidated Appropriations Act of 2020.

PRESCRIPTION DRUG BENEFITS

The Plan provides benefits for drugs or medicines, including insulin, that relate directly to the treatment of an illness of injury and that cannot be legally dispensed without a prescription and that by law must bear the legend “Caution – Federal law prohibits dispensing without a prescription”.

Fertility and weight loss drugs are not covered. The amount of a drug, including insulin, which may be supplied per prescription or refill is the quantity prescribed up to a maximum of a 30-day supply at retail and 31-90-day supply through mail order.

Retail Pharmacy Prescription Services

The Plan provides benefits through a contract with MaxorPlus which contracts for prescription drugs and insulin at discounted rates resulting in savings to the Participant and to the Plan. The Plan uses a copayment structure that reduces the out-of-pocket costs when using generic drugs and preferred brand name drugs. When a prescription is filled at a participating Retail Pharmacy, the copayment will be at one of these tiers:

- **Generic Drugs:** The copayment is $10 for each prescription (up to a 30-day supply);
- **Formulary Preferred Brand-Name Drugs:** The copayment is 20% with a $15 minimum and a $25 maximum for each prescription (up to a 30-day supply);
- **Non-Preferred Brand-Name Drugs / All Other Drugs:** The copayment is 30% with a $30 minimum and a $75 maximum for each prescription (up to a 30-day supply).

RETAIL PHARMACY PRESCRIPTIONS	
Generic Copay:	$10
Preferred Brand Copay:	20%; $15 minimum up to a $25 maximum copayment
Non-Preferred Brand / All Other Copay:	30%; $30 minimum up to a $75 maximum copayment
Retail Pharmacy Copayments will cover a 30-day supply of medication.	

You may obtain up to a 90-day supply of your medication at the Retail pharmacy for the copays defined in the Mail Order pharmacy benefit noted below.

Mail Order Prescription Services

Mail order prescription services are available through ,MXP Pharmacy.

If the prescriptions are obtained through the Mail Order service, the following copayments apply:

MAIL ORDER PHARMACY PRESCRIPTIONS	
Generic Copay:	$20
Preferred Brand Copay:	20%; $40 minimum up to a $75 maximum copayment
Non-Preferred Brand / All Other Copay:	30%; $75 minimum up to a $150 maximum copayment
Mail Order Copayments will cover a 31-90-day supply of medication.	

Covered Prescription Drug Expenses

Covered Expenses are the charges incurred for prescriptions that:

- relate directly to the treatment of an illness or injury and cannot legally be dispensed without a prescription order issued by a legally qualified physician, dentist or podiatrist;
- are for drugs, medicines or supplies which do not normally require a written prescription but are furnished for the Participant who has been medically diagnosed as a diabetic, such as blood/urine glucose/acetone testing lancets; or
- contraceptives prescribed by a physician.

Drug Limitations

There are certain limitations on the benefits provided under this Plan.

Prescription Refills: Refills are subject to the same maximum quantity limit as above and can only be provided in response to a prescription order.

Drug Exclusions

The following are exclusions to the benefits of this section:

1. Drugs for cosmetic purposes – These include anti-wrinkle agents, cosmetic hair removal products and hair growth stimulants.
2. Feeding supplements.
3. Non-drug items, etc. – immunization agents, nose drops, gamma globulin, appliances, non-drug items or injectable drugs normally administered by a physician or nurse.
4. Drugs dispensed by physician – Drugs dispensed to the Participant by a physician, even if the physician charges separately for them.
5. Drugs dispensed in facility – Drugs dispensed to a Participant while a patient in a hospital, skilled nursing facility, nursing home or other health care institution.
6. Drugs available under group policy – Drugs that are covered elsewhere under the Plan, unless the amount payable elsewhere in the Plan is less than the amount payable under this section.
7. Drugs purchased before/after effective date – For any quantity of drugs purchased before the effective date of after the termination of the Participant coverage under the Plan.
8. Prescription drugs utilized for purposes for which the efficacy or safety has not been established or for a use not approved by the FDA.
9. Anti-obesity medications.
10. Growth hormones. (1)
11. Blood or blood plasma.
12. Infertility medications.
13. Any prescription or refill which, considered individually or cumulatively within a time frame, authorizes dosages which exceed the Federal Drug Administration or manufacturer’s recommendations.
14. Drugs prescribed for the treatment of conditions, including experimental uses, which are not within the medical uses approved by the Food and Drug Administration or the manufacturer.

15. Fluoride preparations.

(1) May be covered subject to clinical review by MaxorPlus.

Important Notes:

- **Brand Name versus Generic Drugs** – Unless your doctor specifies that a brand name drug must be dispensed, if you choose to receive a brand name drug for which there is a generic equivalent, you will be responsible for paying both the applicable copayment and the difference in price between the brand name and generic drugs. When you order by mail, PPS will automatically substitute a generic equivalent, if one is available, unless your doctor specifies that a brand name drug must be dispensed.

  If you request a brand name drug, your copayment and the difference in price between the brand name and generic drug will not count toward your annual in-network out-of-pocket maximum.

- **Maintenance Drugs** – Drugs that you use on a regular basis for the long-term treatment of static medical conditions such as high blood pressure, asthma, diabetes, or arthritis are known as "maintenance drugs." Maintenance drugs should be purchased through the Mail Order program from PPS. You will be able to purchase a 31-90 day supply of drugs (versus only a 30-day maximum supply from a Retail Pharmacy) with only a single prescription and copayment.

- If you elected medical coverage through an HMO, you must obtain your prescription drugs through the HMO.

- **Compound Drug Preauthorization –** A prior authorization is required for all compound prescription drugs in excess of $100.00.

For questions concerning Retail pharmacy prescription benefits, contact:

MaxorPlus Customer Service: 1-800-687-8629

For questions concerning Mail Order pharmacy prescription benefits, contact:

MXP Pharmacy Customer Service: 1-806-324-5500

SUPPLEMENTAL ACCIDENT BENEFIT
(For Self-Funded Medical Plan Participants and Dependents Only)

Should you or an injured member of your family need medical attention as a result of accidental bodily injuries within 13 weeks from an accident, your group plan will pay for Usual, Customary and Reasonable Charges up to the Maximum Benefit shown in the Summary of Benefits for the following:

1. Surgery or medical attention performed by a legally qualified doctor of medicine.

2. Hospital care.

3. Nursing care provided by a registered graduate nurse.

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

PODIATRY BENEFIT
(For Self-Funded Medical Plan Participants and Dependents Only)

The Trustees have an agreement with Podiatry Plan of California (PPOC) whereby the participating podiatrist agrees to charge no more than the fee schedule established by PPOC.

UNDER THE AGREEMENT WITH PODIATRY PLAN OF CALIFORNIA (PPOC), IF YOU SELECT A PARTICIPATING PODIATRIST, YOUR 20% CO-PAYMENT WILL BE WAIVED WITH PODIATRY EXPENSES INCURRED REIMBURSED AT 100% BY YOUR TRUST. YOU WILL HAVE NO OUT-OF-POCKET EXPENSE.

Special claim forms will be available at the podiatrist's office which you will be asked to complete. The podiatrist will be paid directly by the Trust. A list of participating podiatrists may be obtained from the Plan Administrator's Office.

If you have questions about foot care in general, you may call PPOC directly, (415) 928-7762, or toll free at 1-800-535-3338. If you have questions about the PPOC program, you may call PPOC directly at the toll-free number or the Plan Administrator’s Medical Claims Department at (408) 288-4481.

REPLACEMENT OF ORGANS OR TISSUE
(For Self-Funded Medical Plan Participants and Dependents Only)

1. The following procedures are payable on the same basis as any other illness:

    a. Corneal transplants.

    b. Artery or vein transplants.

    c. Kidney transplants.

    d. Joint replacements.

    e. Heart valve replacements.

    f. Implantable prosthetic lenses in connection with cataracts.

    g. Prosthetic bypass or replacement vessels.

h. Bone marrow transplants.

i. Heart transplants.

j. Lung transplants.

k. Heart/lung transplants.

l. Liver transplants.

m. Pancreas transplants.

If you or your Dependent incur expenses for transplant surgery as a recipient, the following are included as covered services:

1. The use of temporary mechanical equipment, pending the acquisition of "matched" human organ(s).

2. Multiple transplant(s) during one operative session.

3. Replacement(s) or subsequent transplant(s).

4. Follow-up expenses for covered services (including immunosuppressant therapy).

The Plan will pay the expense incurred by a donor(s) for the following:

1. Testing to identify suitable donor(s).

2. The expense for the acquisition of organ(s) from a donor.

3. The expense of life support of a donor pending the removal of a usable organ(s).

4. Transportation for a living donor.

5. Transportation of organ(s) or a donor on life support.

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

Exceptions

The Plan will not pay for:

1. Any expenses when approved alternative remedies are available;

2. Any animal organ or mechanical (a) equipment, (b) device, or (c) organ(s), except as provided under this provision;

3. Any financial consideration to the donor other than for a covered expense which is incurred in the performance of or in relation to transplant surgery; and

4. Anything excluded under the General Exclusions and Limitations.

Definitions

Transplant Surgery means the transfer of human organs or tissue from one person to another (allograft) or the removal and replacement of tissue in the same individual (autograft).

In addition to the specific limitations set forth in the Plan, transplants remain subject to all other written terms and conditions of the Plan, including, but not limited to, the Plan's precertification and eligibility requirements, definition of Medical Necessity and Usual, Customary and Reasonable rates. ALL TRANSPLANTS MUST BE PRE-AUTHORIZED BY ANTHEM BLUE CROSS.

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

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

Recipient means a covered person who undergoes a surgical operation to receive a body organ transplant.

EXTENDED BENEFITS FOR TOTAL DISABILITY
(For Self-Funded Medical Plan Participants and Eligible Dependents Only)

If you or one of your covered Dependents are totally disabled at the time coverage terminates, Self-Funded Medical Benefits will continue to be available for expenses incurred by the disabled for treatment of that disability for a maximum period of 12 months beyond the date on which coverage terminates but, in no event, beyond the date the disabled person becomes covered under any other group-type plan providing similar benefits.

Any extended benefits payable are subject to the provisions and limitations of the Plan.

MENTAL HEALTH BENEFITS
(For Self-Funded Medical Plan Participants and Eligible Dependents Only)

You must follow the Utilization Review Program described above to receive maximum mental health services. Anthem Blue Cross works with a network of counseling and treatment providers throughout the area. These include psychologists, psychiatrists, marriage and family counselors and social workers where needed, inpatient and outpatient hospitals, and facilities for mental health treatment.

The Plan covers the following mental health services:

1. Mental health outpatient counseling.

2. Psychiatric hospital confinements for approved services at contracting facilities.

3. Psychiatric residential care confinements –covered charges for inpatient residential confinements at approved residential facilities for eligible Employees. Dependent children and spouses who have an AXIS I diagnosis (as defined in the Diagnostic and Statistical Manual for Mental Disorders).

NOTE: Participants enrolled in an HMO plan must use the benefits available through the HMO coverage.

SUBSTANCE USE DISORDER BENEFITS
(For Self-Funded Medical Plan Participants and Eligible Dependents Only)

The Plan has two PPO provider networks for alcohol and/or substance use disorder benefits: Beat It! and Anthem Blue Cross. Beat It! is a specialty program for the treatment of problems with alcohol and drug abuse. The phone number to contact Beat It! alcohol and drug abuse treatment counselors is (408) 436-2392 or toll-free 1-800-828-3939. Calls to Beat It! are confidential.

Inpatient Treatment provided by In-Network Provider: The Plan will pay 80% of Covered Charges of eligible expenses after the deductible has been satisfied.

Outpatient Treatment provided by In-Network Provider: The Plan will pay 80% of Covered Charges of eligible expenses after the deductible has been satisfied.

Inpatient Treatment provided by Out-of-Network Provider: The Plan will pay sixty percent (60%) of all Usual, Customary, and Reasonable Charges in excess of the applicable annual deductible.

Outpatient Treatment provided Out of Network Provider: The Plan will pay sixty percent (60%) of all Usual, Customary, and Reasonable Charges in excess of the applicable annual deductible.

SMOKING CESSATION BENEFITS
(For Self-Funded Medical Plan Participants and Eligible Dependents Only)

The Plan will pay 100% of the costs of smoking cessation programs, and of smoking cessation aids associated with qualified programs within the following quantity limits:

1. Screening for tobacco use; and

2. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt will include up to:
   - Four smoking cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
   - All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

Services at non-Contracting facilities are limited to 60% of normal benefits, the same limits regarding counseling sessions and prescription drugs apply.

EXCLUSIONS, LIMITATIONS & NON-COVERED CHARGES

No benefits are provided for:

(a) Services or supplies that are not medically necessary for the treatment of an illness or injury;

(b) Any injury or sickness for which you are not treated by a legally qualified physician or surgeon;

(c) Dentistry;

(d) Eye refractions, or the fitting of glasses;

(e) Injury or illness occurring in the course of employment for wages or profit;

(f) Any injury or illness for which you could receive benefits under any worker's compensation law or occupational disease law or for which you could receive any settlement from a worker's compensation insurer;

(g) Any service unless a charge is made for such service which the Employee is required to pay;

(h) Cosmetic services, except for photochemotherapy treatment of vitiligo for those under age 21 (There will be a $5,000 limit for this treatment.);

(i) Experimental or investigational services; if an Employee or eligible Dependent is eligible to participate in an approved clinical trial for the treatment of cancer or other life-threatening disease, the Plan will not prohibit the Employee or eligible Dependent from participating in the clinical trial or discriminate against the Employee or eligible Dependent for participating in the clinical trial. The Plan will cover Routine Patient Costs for items or services furnished during the clinical trial. Routine Patient Costs shall mean all items and services consistent with the coverage provided in the Plan that are typically covered for an Employee or eligible Dependent who is not enrolled in a clinical trial. Routine Patient Costs do not include (i) the investigational item, device or service itself; (ii) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(j) Preventive Care for out-of-network providers (except that out-of-network preventive care for Coronavirus will be covered by the Plan);

(k) Out-of-network contracted hospital charges for Well-Baby care;

(l) Confinement in a U.S. Government hospital or any surgical, medical, or other treatment, services or supplies received in or from such a hospital, or for any confinement, services or supplies furnished without charge or reimbursed by the Federal Medicare Plan, state or other governmental program or for which no charge is made that the Employee or any of his/her Dependents is required to pay;

(m) Orthodontics unless medically necessary;

(n) Any hospitalization which is primarily for custodial care not involving medical treatment;

(o) Family Planning: Services and supplies for artificial insemination, in vitro fertilization, diagnosis or treatment for infertility, or surgery to correct voluntary sterilization;

(p) Radial keratotomy;

(q) Any treatment, services, appliances or surgery related to treatment of temporomandibular joint pain or syndrome (the temporomandibular joint is the joint between the temple and the jaw), as either a medical or dental expense unless pre-approved;

(r) Services associated with sex transformation and resulting complications;

(s) Penile implants unless required as a result of injury or an organic disorder;

(t) Any service or supply relating to any evaluation, treatment or therapy involving the use of high-dosage chemotherapy and adjuvant autologous bone marrow transplant, autologous peripheral stem cell rescue, or autologous stem cell rescue for any disease other than acute lymphocytic leukemia and acute non-lymphocytic leukemia, Hodgkin’s' disease, non-Hodgkin’s' lymphoma, neuroblastoma, or germ-cell malignancies; or

(u) Any home health care, except:

(1) The Plan will cover the medical component of home health care provided as part of hospice due to personal injury or sickness; and

(2) The Plan will cover the medical component of home health care as approved by Blue Cross in lieu of hospitalization due to personal injury or sickness.

(v) Losses that are due to war or any act of war, whether declared or undeclared;

(w) Any illness, injury, disease or other condition for which a third party may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

OUTPATIENT LABORATORY BENEFITS
(For Self-Funded Medical Plan Participants and Dependents Only)

The Plan covers expenses for outpatient lab tests ordered by your doctor.

If you utilize an in-network clinic for lab services, the Plan pays 100%. If you use an out-of-network provider, the Plan will pay 60% of the Usual, Customary and Reasonable Charges following your calendar year deductible being met.

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

QUALIFIED LONG TERM CARE SERVICES
(For Self-Funded Medical Plan Participants and Dependents Only)

The Plan will cover the cost of qualified long-term care services for Active Employees and their eligible Dependents, subject to the following conditions and limitations:

(a) Conditions requiring long term care services. The individual must be certified as chronically ill by a Licensed health care practitioner. A chronically ill individual is unable to perform at least two activities of daily living without substantial assistance from another individual, due to a loss of functional capacity by reason of personal injury or sickness which can be expected to result in death or to be of long-continued and indefinite duration. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence.

(b) Waiting period. The condition that caused the individual to be unable to perform at least two activities of daily living without substantial assistance must have existed for at least twenty-four (24) months, as demonstrated by a Social Security disability award, or if no award, then satisfactory medical evidence that the condition has existed for at least sixty (60) months.

(c) Covered services. The Plan will cover the cost of the following in-home long term care services: necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance and personal care services that are required by a chronically ill individual and provided pursuant to a plan of care prescribed by a licensed health care practitioner. The Plan may require periodic verification of the services provided.

(d) Benefit amount. After the applicable waiting period, the Plan will pay 50% of the expense incurred for covered services up to $15 per hour for a maximum of ten hours of in-home care per weekday. The provider will be reimbursed directly by the Plan.

(e) Eligible Providers. The provider must be a licensed caregiver and cannot be a family member.

(f) Co-payments. The Employee must pay at least 50% of the cost of the home health caregiver. The Plan will require verification of such payment at least annually.

(g) Annual Certification by a Licensed Health Care Practitioner. The Plan shall require annual certification by a licensed health care practitioner that the individual is a chronically ill individual, as defined in this section.

DIABETES MANAGEMENT TRAINING
(For Self-Funded Medical Plan Participants and Dependents Only)

You and your eligible Dependents may receive diabetes management training, which includes nutritional counseling, glucose testing, medications and insulin injections.

DENTAL BENEFITS

SELF-FUNDED DENTAL BENEFITS FOR ACTIVE AND CATEGORY 2 EMPLOYEES AND DEPENDENTS

Dental Expense Benefits

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

Preferred Provider Dentists

Under this plan you are free to use any dentist of your choice. However, the Trustees have negotiated lower charges with certain dentists through Anthem Blue Cross Dental PPO, called "preferred providers." The network of preferred providers is called "Dental Preferred Provider Organization" or "Dental PPO". Because the Plan saves money when you use a preferred provider dentist, you as a participant also save money when you use a preferred provider dentist. To receive the Plan's highest level of benefits and pay the lowest out-of-pocket costs, use an Anthem Blue Cross Dental PPO network dentist. To locate a participating preferred provider dentist, visit www.anthem.com/ca or call (408)288-4400.

Charges incurred at a PPO Dentist are paid at the In-Network level of 100% of the Contract Rate for Class I services, 80% of the Contract Rate for Class II services and 60% of the Contract Rate for Class III services. Class II and III Services are subject to a $50 per person and a $150 per family per year deductible. Charges for Class IV, Orthodontia Services, are covered at 60% of the Contract Rate with a lifetime maximum benefit of $2,000 per person. Class IV Services are not subject to a deductible.

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

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

Usual, Customary and Reasonable Charges

All dental benefits are subject to usual, customary and reasonable (UCR) guidelines. These guidelines help control Plan costs by setting a limit on the amount covered for each dental procedure. The usual, customary and reasonable charge for each service or supply you receive will be the lesser of these two amounts:

- The fee usually charged by your Dentist for these services and supplies, or
- The fee usually charged by other Dentists in the same geographical area for these services and supplies.

You are responsible for any amounts that are more than usual, customary and reasonable charges.

Non-PPO Dentist

Charges incurred at a Non-PPO Dentist will be paid at the Out-of-Network benefit level of 100% of Usual, Customary and Reasonable Charges for Class I Services, 80% of Usual, Customary and Reasonable Charges for Class II Services and 60% of Usual, Customary and Reasonable Charges for Class III Services. Class III Services are subject to a $50 per person and a $150 per family per year deducible. Charges for Class IV, Orthodontia Services, are covered at 60% of Usual, Customary and Reasonable Charges with a lifetime maximum benefit of $2,000 per person. Class IV Services are not subject to a deductible.

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

Alternate Courses of Treatment

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

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

Pre-Estimation of Costs – Submitting a Treatment Plan

For all dental treatment expected to cost $500 or more, your Dentist should submit a treatment plan to the Plan Administrator. This way, the Plan Administrator can advise you in advance how much you will have to pay for the proposed treatment.

- Ask your Dentist to prepare a treatment plan and send it to the Plan Administrator.
- You and your dentist will receive an explanation of benefits (EOB) that details the benefits payable under your Plan. This is called a predetermination of benefits.
- A predetermination of benefits is good for 90 days. However:
  - You must be covered for dental benefits when treatment is received; and
  - The benefits payable are subject to all Plan maximums.
  - If you do not receive treatment within 90 days of the date the Plan Administrator approves benefits, your Dentist should submit a new treatment plan.

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

Maximum Benefits

For Class I, II, and III services there is no maximum benefit for dependent children under age 19. For eligible employees, eligible dependent spouses, and eligible dependent children 19 and over there is an annual maximum of $2,000 per calendar year for Class I, II, and III services. The maximum benefit for Class IV service is $2,000 per lifetime.

The Trustees may approve advancement of annual dental maximums, up to four (4) years, only if they determine in their sole discretion that the participant will suffer extreme detriment if the services are not rendered.

Covered Dental Services

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

Class I - Diagnostic/Preventative Services

1. Oral examinations, including scaling and cleaning of teeth, but not more than two (2) examinations or scaling and cleaning in any calendar year.

2. Topical application of sodium or stannous fluoride, two (2) times in a calendar year, but only if the insured family member has not yet attained the age of 15 years.

3. Bite wing X-rays.

   Preventative treatment also includes a full-mouth series of x-rays once in any 2-year period.

4. For dates of service on or after March 1, 2020 until the end of the 2019 novel coronavirus Public Health Emergency declared by the Secretary of Health and Human Services, Personal Protective Equipment (PPE) required by the CDC and California guidelines to reduce the risk of viral transmission and infection of COVID-19, up to $10.00 per visit.
5. For dates of service on or after March 1, 2020 until the end of the 2019 novel coronavirus Public Health Emergency declared by the Secretary of Health and Human Services, teledental visits up to $46.00 per visit. Teledental visits include all remote dental provider services conducted via telephone, video, or other online capability.

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

Class II - Basic Services

1. Dental X-rays - other than bitewing.

2. Extractions.

3. Oral Surgery, including extractions and excision of impacted teeth.

4. Amalgam, silicate, acrylic and composite fillings. Silicate, acrylic and composite fillings are covered only for teeth in front of the first bicuspid.

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

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

8. Injections of antibiotic drugs by the attending dentist.

9. Space maintainers.

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

10. Endodontic treatment, including root and canal therapy.

Class II Services will be covered at 80% of the Usual, Customary and Reasonable Charges, subject to a $50 per person and a $150 per family per year deductible.

Class III - Major Services

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

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

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

3. The replacement of a full denture which is necessary because of

   (a) Structural change within the mouth, but only if more than five years has elapsed since the initial placement;

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

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

4. Replacement of, or addition of teeth to, an existing partial or full removable denture or fixed bridgework by a new denture or by a new bridgework, but only if

   (a) The replacement or addition of teeth is required to replace one or more additional natural teeth extracted while insured under this provision and after the existing denture or bridgework was installed; or

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

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

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

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

Class III Services will be covered at 60% of the Usual, Customary and Reasonable Charges, subject to a $50 per person and a $150 per family per year deductible.

Class IV - Orthodontic Services

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

Class IV Services will be covered at 60% of the Usual, Customary and Reasonable Charges. No deductible applies.

The maximum lifetime amount payable for orthodontic benefits is $2,000 per person.

EXCLUSIONS AND LIMITATIONS FOR THE ACTIVE AND RETIREE DENTAL BENEFIT PLANS

Exclusions:

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

2. Services to correct any congenital defect or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons.

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

4. Hospitalization.

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

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

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

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

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

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

11. Charges for completion of claims forms.

12. Charges for dental appointments that are not kept.

13. Experimental procedures.

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

15. Take-home fluoride solutions.

16. Treatment of any injury, illness, or disease or other condition for which a third party (individual or organization) is or may be considered responsible.

Limitations:

The benefits as outlined are subject to the following limitations:

1. X-rays: Complete mouth X-rays are provided only once in a two (2) year period, unless special need is shown.

2. Prophylaxis: Prophylaxis (cleaning and scaling) including fluoride treatment for children is covered not more than two (2) times during any calendar year

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

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

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

Claim Disputes

See "Claims and Appeals Procedure."

VISION CARE BENEFITS

VISION CARE BENEFITS
FOR ACTIVE AND CATEGORY 2 EMPLOYEES,
DEPENDENTS AND RETIREES

How the Vision Plan Works

Eye care is an important part of your overall health. That is why the Plan provides vision coverage through Vision Service Plan (VSP). You can save money on your vision expenses by using doctors who are part of the VSP network.

When you Need Vision Care:

- Save money by scheduling an appointment with a VSP doctor.
- You also have the option to see the optometrist, ophthalmologist or optician of your choice that is not on the Plan; however, you will pay more out of pocket and there will be claim forms to file.
- Call VSP at 1-800-877-7195 for a list of VSP doctors, or visit VSP's website at www.vsp.com.

VSP Doctors

If you select a VSP doctor, the Plan provides covered services after the $10 copay for the vision exam. You will be responsible for any cosmetic options not covered by the Plan or a frame that is over the allowance.

Non-VSP Providers

If you choose to receive vision care from a non-VSP provider, you will be reimbursed for covered expenses according to a schedule. You must call VSP at 1-800-877-7195 or the Plan Administrator for information about the schedule. In order to be reimbursed, you must submit receipts within six months of the date you incur expenses for covered services.

How to Get Vision Benefits

From a VSP Doctor:

1. Call VSP at 1-800-877-7195 for a list of doctors in your area. You can also get a list of VSP member doctors at www.vsp.com.
2. Select the VSP doctor of your choice from the list, call him or her and make an appointment. Identify yourself as a VSP member. The participating doctor will need the covered member's Social Security number, and the Plan Trust name (IBEW Local #332 Health & Welfare Trust). The VSP doctor will call VSP to verify your eligibility and coverage. He or she will also obtain authorization for services and materials. If you are not eligible, the VSP doctor will notify you. Call the Plan Administrator at 1-800-541-8059 if there is a problem with your eligibility.
3. At your appointment, the VSP doctor will examine your eyes. If eyewear is necessary, the VSP doctor will coordinate the prescription with a VSP-approved laboratory. VSP will pay the doctor directly for covered services and materials.

From a Non-VSP Provider

1. Call VSP to verify your eligibility for services.

2. Make the appointment with the provider you select and pay the provider his or her full fee. Ask for a copy of the bill that shows the amount of the eye examination, lens type and frame.
3. With your itemized bill, you must include the following information on a separate form or sheet of paper:
   - Member's name, telephone number, and mailing address.
   - Member's Social Security number
   - Member's Trust name, and
   - Patient's name, address, telephone number, date of birth and relationship to member.
4. Mail the itemized bill and your information to:

   Vision Service Plan
   Attention: Out-of-Network-Provider Claims
   P.O. Box 997105
   Sacramento, CA 95899-7105

This documentation must be submitted within six months after the date on which the service was provided. You should send the originals to the Vision Service Plan and keep copies for your records.

Vision Expenses That Are Covered

Vision Benefits Schedule

Benefit	VSP Provider	Non-VSP Provider	How Often?
Vision Exam	Covered in full after $10 copay	Covered up to $50	Once every 12 months
Prescription Glasses			
Lenses	Covered in full after $25 copay except for cosmetic options not covered by the Plan	Covered up to: $50/single vision $75/bifocal $100/trifocal $75/progressive lenses	Once every 12 months
Frames	Covered in full after $25 copay up to the Plan allowance, plus 20% off on amount over allowance • $170 featured frame brand allowance • $150 frame allowance • $80 Costco frame allowance	Covered up to $70	Once every 12 months
Contacts			
Contact Lenses	Up to $60 copay	Covered up to $105	Once every 12

(instead of glasses)	$150 allowance for contacts (copay does not apply)		months
Primary Eye Care			
Primary Eye Care	• Retinal screening for members with diabetes ($0 copay) • Additional exams and services for members with diabetes, glaucoma, or age-related muscular degeneration ($20 copay per exam) • Treatment and diagnosis of eye conditions, including pink eye, vision loss, and cataracts available for all members.	Not Covered	As needed
Safety Glasses (Active Employee-Only Coverage)			
Safety Eye Exam	$0	Not Covered	Once every 12 months
Frame & Lenses	• $65 allowance for a safety frame • 20% savings on the amount over allowance • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	Not Covered	Once every 12 months

Note: There is a $25 materials copayment.

Spectacle Lenses and Frame

VSP offers a wide selection of covered frames, but not all frames will be covered in full. If you select a frame that is more than the Plan's allowance, you are responsible for paying the additional charges. The charges are typically less than reasonable and customary fees. VSP provides a 20% discount on non-covered pairs of prescription glasses. They must be purchased from the same doctor who provided the eye exam and within 12 months of that service.

Spectacle lenses, including standard progressive lenses, are covered in full after the $25.00 copayment. Active and retired participants are eligible for spectacle lenses once every 12 months.

Active and retired participants, and eligible dependents are eligible for a frame once every 12 months.

Contact Lenses

Elective contact lenses – An allowance will be provided toward the standard eye exam, contact lens evaluation, fitting costs and materials. Any costs above the allowance are your responsibility.

VSP also offers a 15% discount of the participating doctor's professional services when you purchase prescription contact lenses. Materials are provided at reasonable and customary fees. This benefit is available in conjunction with your VSP contact lens allowance, or you can use it to purchase contacts in lieu of glasses.

Medically necessary contact lenses are covered in full when prescribed by a participating doctor for certain conditions. A VSP doctor must receive prior approval from VSP for medically necessary contact lenses.

Extras Available for Additional Fees

The Plan is designed to cover visual needs rather than cosmetic materials. When you select any of the following extras, VSP will pay the basic cost of the allowed lenses and you will pay the additional costs at a cost-controlled price for:

- Frames that cost more than the Plan allowance;
- Contact lenses (except as provided in the schedule of benefits);
- Optional cosmetic processes;
- Anti-reflective coating;
- Color coating;
- Mirror coating;
- Scratch coating;
- Blended lenses;
- Cosmetic lenses;
- Laminating of the lens or lenses;
- Certain limitations on low vision care;
- Oversize lenses;
- Progressive multifocal lenses; and
- UV (ultraviolet) protected lenses

Note: Retirees must elect vision coverage for themselves and their dependents and make the appropriate self-payments for coverage in order to receive vision benefits.

Prescription Safety Eyewear

In addition to eye care benefits covered by the Plan, the Plan also covers prescription safety eyewear for active participants only. Benefits for safety eyewear are only available through a VSP doctor. Benefit amounts are shown in the chart starting on page 59.

Note: The Plan does not cover expenses for Safety Eyewear if you use a non-VSP provider.

What are Safety Glasses?

Safety glasses feature a frame constructed so that, if impacted from the front, the lens will not come out the back of the frame. Safety lenses are three millimeters thick at the thinnest point. The lens must be impact-tested and monogrammed by the fabricating laboratory indicating that it is a safety lens. Contact lenses do not meet the test requirements and therefore are not included in this safety eyewear benefit.

How to Get Safety Eyewear

1. Call VSP at 1-800-877-7195 for a list of VSP doctors (or access www.vsp.com).
2. Contact the VSP doctor to make an appointment and indicate that you are requesting safety glasses. Identify yourself as a VSP member and provide the doctor's office with your Social Security number, and the name of the Plan Trust (IBEW Local #332 Health & Welfare Trust). The VSP member doctor will call VSP to verify your eligibility and Plan coverage.
3. When you visit the VSP doctor, you will have no other expenses unless you select optional items that the Plan does not cover.

Vision Expenses That Are Not Covered

The Plan does not cover the following vision care expenses:

- Orthoptics or vision training and any associated supplemental training, plano lenses (non-prescription), or a second pair of glasses in lieu of bifocals;
- Lenses and frames furnished under this program that are lost or broken, except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of eyes, which is covered through the medical portion of this Plan;
- Any eye examination, or any corrective eyewear, required by an employer or a governmental body or agency as a condition of employment;
- Corrective vision services, treatments, and materials of an experimental nature.

Claim Questions?

If you have questions about a claim, call VSP at 1-800-877-7195.

Claims for reimbursement must be filed within six months of the date services were completed.

Claim Appeal Procedure for all Vision Care Benefits

If your claim for vision benefits is denied in whole or in part by VSP, you may appeal the denial. Appeals must be sent to VSP within 60 days of the denial and include your name, Social Security number, date of birth and any comments or arguments concerning the appeal. In connection with the appeal, you may review any pertinent nonprivileged document in the possession of VSP. You will receive the resolution of your appeal in writing. Send your appeal to:

Vision Service Plan
Attn: Claim Appeal Dept.
PO Box 997105
Sacramento, CA 95899-7105

HEARING CARE BENEFITS

HEARING CARE BENEFITS
FOR ACTIVE AND CATEGORY 2 EMPLOYEES,
ELIGIBLE DEPENDENTS AND RETIREES

The following hearing care benefits are provided when provided by a physician, certified audiologist or licensed hearing aid dealer:

Routine Hearing Exams and Hearing Aid Evaluation Tests

The Plan will cover one hearing examination or hearing aid evaluation test in any twenty-four (24) month period, limited to a maximum benefit payment of $30 per examination.

Hearing Aids

This benefit is limited to one hearing aid per twenty-four (24) month period for each ear. Eligibility for a replacement aid or aids becomes effective twenty-four (24) months (730 days) from the order date of the previous aid obtained and covered under the Plan.

If it is medically substantiated that an aid is required, the Plan will allow reimbursement to you for one of the stated maximums listed below:

- For a monaural aid (one) in either ear, the Plan will allow a maximum of $500.
- For binaural aids (an aid in each ear), the Plan will allow up to a maximum of $1,000.
- For a CROS (contralateral routing of signals for unilateral hearing loss), the Plan will allow up to a maximum of $1,000.
- For hearing aid expenses in excess of the allowable Plan maximums, the Plan will pay 50% up to a maximum of $1,000.

The Plan's deductible and coinsurance provisions do not apply to this benefit.

EXCLUSIONS AND LIMITATIONS

1. Those drugs or other medications prescribed in conjunction with the hearing aid. The prescriptions (legend drugs only) should be submitted separately under your prescription drug program.
2. Any service which is already covered under your medical plan, worker's compensation, or any other plan or organization.
3. Reimbursement for the cost of the hearing aid evaluation test or the purchase of the hearing aid after termination of benefit coverage with the Plan.
4. Replacement parts or batteries for hearing aids.
5. Any charges for the completion of insurance forms.
6. Replacement or repair of hearing aids that have been lost or broken unless, at the time of the replacement, the covered person is again eligible (i.e., 24 months [730 days] have transpired since services were last covered).
7. Charges for hearing aid evaluation tests and/or hearing aids which are not necessary according to professionally accepted standards of practice or which are not recommended or approved by the physician.

8. Charges for hearing aid evaluation tests and hearing aids that do not meet professionally accepted standards of practice, including charges for any such services or supplies that are experimental in nature.

CHEMICAL DEPENDENCY BENEFITS

BEAT IT!
PRESCRIPTION FOR CHEMICAL DEPENDENCY

FOR ACTIVE AND CATEGORY 2 EMPLOYEES, EARLY RETIREES AND ELIGIBLE DEPENDENTS

The Plan's PPO provider for alcohol and/or substance abuse is the organization Beat It! Beat It! is a specialty program for the treatment of problems with alcohol and drug abuse. The Beat It! program is available to all active qualified participants, Early Retirees who are not eligible for Medicare and their eligible Dependents, including members who have chosen one of the HMO plans offered for medical coverage. The benefits include inpatient treatment in an approved facility or an outpatient counseling program with an approved counselor as described below.

Inpatient Treatment provided by BEAT IT: If an eligible employee or dependent uses Beat It! for inpatient treatment, the Plan will pay eighty percent (80%) of your covered charges of the first $3,000 ($6,000 per family unit) of eligible expenses and will pay one hundred percent (100%) (instead of eighty percent (80%)) of covered charges for the remainder of the calendar year.

Outpatient Counseling provided by BEAT IT!: If an eligible Employee or Dependent uses Beat It! for outpatient counseling, the Plan will pay eighty percent (80%) of the covered charges after the applicable annual deductible has been satisfied.

The phone number should be used for direct connection to the alcohol and drug abuse treatment counselors. They will assist you with counseling and making arrangements for care. Please call (408) 436-2392 or toll-free 1-800-828-3939.

All calls and information are confidential.

BEAT IT!
(408) 436-2392
1-800-828-3939

RETIREE PLAN (BUE)

RETIREE PLAN
FOR BARGAINING UNIT EMPLOYEES (BUE)

The Trustees have established the Retiree Plan of the I.B.E.W. 332 Health and Welfare Trust Fund on the basis that the employer contributions on the Active Employees will, if continued, maintain this plan for Retirees. All Retirees, regardless of whether they qualify for Medicare or not, will receive a partial subsidy from employer contributions earned by the Actives. However, it is recognized that the benefits provided by this Plan can be paid only to the extent that the Trust has available adequate resources for those payments. The Trustees retain the right in their sole discretion to reduce benefits of the Retiree Plan, to reduce or eliminate the subsidy for benefit coverage to the Retirees, and to use Trust reserves for benefit coverage for Active Employees or Retirees. The Retiree coverage is not a vested benefit. This benefit is provided at the sole discretion of the Trustees.

No participating employer has any liability, directly or indirectly, to provide the benefits established by this Plan beyond the obligation of the participating employer to make contributions as stipulated in the Collective Bargaining Agreement (CBA) or the Trust Agreement. In the event that at any time the Trust does not have sufficient assets to permit continued payments under this Plan, nothing contained in this Plan or the Trust Agreement shall be construed as obligating any participating employer to make benefit payments or contributions other than the contributions that the participating employer may be obligated for under the CBA or Trust Agreement. Likewise, there shall be no liability upon the Trustees, individually or collectively, or upon the Contractor, Employer Association, or Local Union to provide the benefits established by this Plan if the Trust does not have assets to make such benefit payments, or should the Trustees in their discretion utilize Trust assets for benefits other than subsidizing the Retiree Plan.

Minimum Eligibility Requirements for All Retirees

1. You must be retired under the I.B.E.W. Local 332 Pension Plan Part A or B.

2. You must be age 62 or over.

3. You must be drawing Social Security benefits.

4. You must have been covered under the Active Employee Plan for a minimum of 55 of the last 60 covered months immediately prior to retirement. (All months of coverage as an active participant, including months of self-payment, will be considered in determining your eligibility under this rule. If you retire on or after age 60 under the I.B.E.W. Local 332 Pension Plan Part A or B, you may make self-payments at the prescribed rate for continued coverage under any one of the Active Plans for up to 24 months, and any such months of self-payment will be counted in determining whether you are eligible for coverage under the Retiree Plan when you reach age 62.)

5. If you are eligible for Medicare, you must enroll in both Part A and Part B of Medicare and must assign your Medicare Part B payments to the Medicare Supplement Plan you select, as described below. If your spouse is eligible for Medicare, he/she must also enroll in Part A and assign the Part B payments to the Medicare Supplement Plan he/she selects.

6. You must make a monthly payment to the Plan to help cover the cost of your benefit coverage. The amount of the monthly payment is established by the Board of Trustees. Payments for the Retiree, spouse, and Dependents (if eligible under the Retiree Plan) must be made without interruption. If there is a lapse in payments your coverage will terminate and cannot be reinstated. The amount of the monthly payment for Retirees who are eligible for Medicare is based on the amount of monthly pension that they are receiving from the

IBEW Local 332 Pension Plan Part A. The monthly payment amount is subject to change from time to time at the discretion of the Trustees. Please contact the Plan Administrator for the current premium amounts.

7. You must apply for the Retiree Plan through the Plan Administrator within 30 days after you are no longer an active employee or else risk losing coverage under the Plan.

9. Employees who obtain disability retirement under the I.B.E.W. Local 332 Pension Plan and who also fulfill the minimum coverage requirements shall be eligible, after exhausting the maximum twelve (12) month free disability coverage and any individual reserve, to make self-payments under the Regular Plan for Active Employees until age sixty-two (62), at which time the Employee may transfer to the Retiree Plan. The disabled retiree may transfer to the Retiree Plan at an earlier date if approved for Medicare benefits and the minimum coverage requirements have been met.

The spouse and Dependents of a Participant will continue to be eligible for coverage under the Retiree Plan if the Participant was approved as eligible for coverage under the Retiree Plan but passed away in the month preceding his/her retirement effective date. All other terms of coverage continue to be applicable, including but not limited to monthly premium payments, enrollment in Medicare Parts A and B when eligible, and termination of coverage provisions.

Retiree Health Benefits

As a Medicare-eligible Retiree, you have the choice of three different Medicare Advantage plan providers: Kaiser Permanente / Senior Advantage, HealthNet and United Health Care / Secure Horizons. Each of the three includes a prescription drug benefit. Further explanation of the benefits may be found in the brochures from each Medicare Advantage plan provider, which are available to you, upon request, from the Plan Administrator at no additional cost. Read this information carefully to determine the conditions under which these benefits are payable. The Plan also offers a traditional Medicare Medigap / Supplement Plan F through the Hartford Life Insurance Company. This option does not include a prescription drug benefit. All Retirees have vision, hearing care and Retiree dental benefits under the Self-Funded Plan. Early Retirees who are not eligible for Medicare will also receive chemical dependency benefits.

The Retiree, spouse and dependents may change their medical provider annually during the open enrollment period set by the Board of Trustees.

Early Retirees and/or Retirees' spouses not eligible for Medicare who had elected medical coverage under the Self-Funded Plan and who were covered under that Plan as of June 30, 1996 may continue coverage under the Self-Funded Plan until they become eligible for Medicare, at which time the Retiree and/or spouse will be required to enroll in one of the Medicare supplement plans. The Self-Funded Plan is not available to any Retiree or spouse who was not already receiving benefits under that Plan as of June 30, 1996.

Early Retirees and/or Retirees’ spouses and dependents not eligible for Medicare are eligible to elect medical coverage under the Self-Funded Plan.

The Self-Funded Plan includes all the covered charges listed under the Active Plan with benefits provided on the basis of a $250 per individual calendar year deductible, with an 80%-20% co-insurance feature for Anthem Blue Cross Providers. The Utilization Review Program and the list of Preferred Provider Organization (PPO) providers should be reviewed prior to any hospitalization under the Self-Funded Plan. The list of PPO providers is provided to you automatically and free of charge as a separate document.

Dependent Coverage

Early Retirees and Retirees can enroll their spouse and/or other Dependent(s), as defined in the Definition of Terms section of this booklet, in medical coverage under the Plan.

Out-of-Area Retirees

The Plan will not provide reimbursement to a Retiree or Retiree's Dependents toward the cost of a different Medicare Supplement Plan or an alternative pre-paid health plan. Medicare-eligible Retirees and/or their dependents that reside outside the geographic service area of the Medicare Advantage plan providers offered may elect the Hartford Life Insurance Company Medicare/Medigap Supplemental Plan F for themselves and their eligible dependents. The monthly premium for Hartford Life coverage is paid by the Plan after the Retiree pays the applicable monthly premium.

A Medicare-eligible Retiree and his/her spouse who reside outside the geographic area served by any of the Medicare Advantage plan providers as of December 31, 2014 will be eligible for dental, vision and hearing aid coverage at no cost to the Retiree effective June 1, 2015. These benefits are only available to those Medicare-eligible retirees living out of the area as of December 31, 2014.

A Medicare-eligible Retiree who moves outside the geographic service area of the Medicare Advantage plan providers on or after January 1, 2015 must be enrolled in the Hartford Life Insurance Company Medicare/Medigap Supplemental Plan F to receive dental, vision and hearing aid coverage.

A Retiree and/or Retiree's Dependent(s) who is not Medicare eligible and who does not reside inside the geographic service area for one of the coverage options provided by the Plan for Retirees who are not Medicare eligible, may delay Retiree coverage under this Plan until becoming Medicare eligible. At that time the Retiree and/or Retiree's spouse may enroll in the Hartford Life Insurance Company Medicare/Medigap Supplemental Plan F.

Effective Date of Coverage

You and your Dependents become covered on the date of eligibility approved by the Board of Trustees. The Retiree Plan covers the retired Employee, spouse and Dependents.

Delayed Effective Date While Covered by Spouse's Plan

You may postpone the effective date of Retiree coverage under this Plan if (1) you are covered under your spouse's group health plan when you retire and (2) you apply for coverage and commence any required payments to this Plan within thirty (30) days after coverage under your spouse's plan ceases. If you do not begin making payments to this Plan at the time you retire, you will not be permitted to make such payments until your coverage under your spouse's plan ends or is substantially reduced. You will be required to submit satisfactory evidence that you were covered under your spouse's plan during the deferral period and that your coverage under that plan has ended. You and your spouse may both defer coverage under these rules. If you elect immediate coverage under this Plan, your spouse may independently choose to defer his/her effective date in accordance with these rules.

Opt Out While Covered by the VA

If you meet the eligibility requirements to be covered by the Retiree Plan you may opt out of coverage under this Plan when receiving coverage from the United States Department of Veterans Affairs ("VA"). If you have an eligible spouse, your spouse may continue to be covered by this Plan even if you have opted out of this Plan.

Delayed Effective Date for Pre-Medicare Retirees While Covered by Exchanges

If you are a Pre-Medicare Retiree and are not eligible for the Pre-Funded Early Retiree Plan, you may postpone the effective date of Retiree coverage under this Plan if (1) you purchase health coverage on the Exchanges established by the Patient Protection and Affordable Care Act ("Exchanges") when you retire and (2) you apply for coverage and commence any required payments to this Plan within thirty (30) days after your coverage through the Exchanges ceases. You will be required to submit satisfactory evidence that you had coverage through the Exchanges during the deferral period and that your coverage under that plan has ended. You, your spouse, and Dependents may both defer coverage under these rules.

Changes to Report

From No Spouse to Spouse - If you marry after you become eligible, you can obtain coverage for your spouse. In order to add spouse's coverage, you should notify the Plan Administrator's Office within 31 days after the date of marriage and coverage will become effective on the date of marriage.

Adding a Dependent Child – if you acquire a new Dependent Child you should notify the Administrative Office as soon as possible. Coverage will begin on the date the child became an eligible Dependent Child as defined in the Defined Terms Section of the Booklet.

From Spouse to No Spouse - In the event of death or divorce of your spouse, you must notify the Administrative Office as soon as possible and his/her coverage will be terminated.

A spouse who loses coverage due to divorce may purchase COBRA continuation coverage for up to 36 months. Please refer to the COBRA requirements on page 6.

Termination Upon Returning to Active Status

If you are covered under the Retiree Plan and you return to active status, your coverage under the Retiree Plan will terminate as of the last day of the month in which you return to active status. If you return to active status and subsequently retire, you must apply for the Retiree Plan with the Administrative Office.

If you return to active status you must requalify, in accordance with the eligibility requirements of the Active Plan, for coverage under the Active Plan. Self-pay privileges will not be available during any period of lapse in coverage due to returning to active status.

Notwithstanding the above, effective September 1, 2017, a Medicare-Eligible Retiree who works fewer than 40 hours a month for a Contributing Employer shall remain eligible for coverage under the Retiree Plan.

Termination of Coverage

Your coverage will terminate if the Plan is terminated or you cease to be a member of a class eligible for coverage under the Retiree Plan.

Coverage for your spouse will terminate when he/she ceases to be an eligible Dependent (e.g., divorce), when the Plan is terminated, when you cease to be eligible for spouse's coverage, or when your own coverage terminates.

Coverage for your Dependent(s), other than your spouse, will terminate when he/she ceases to be an eligible Dependent, when the Plan is terminated, or when your own coverage terminates.

If your coverage under the Plan ceases because of your death, coverage may be continued by your surviving spouse. Your surviving spouse must contact the Administrative Office to determine if coverage

is to continue. Coverage will be continued on the same basis for your surviving spouse except that the coverage will cease when your spouse remarries or dies, subject to the COBRA requirements (Refer to page 6).

Notwithstanding the above, coverage for your spouse will automatically end on the date of your divorce or legal separation, or on the first day of the month in which any of the following events occur: i) your spouse reaches age 65, ii) your spouse is under age 65, eligible for Medicare because of disability and does not remain continuously covered by Medicare Parts A and B; or iii) a monthly premium is not received by the Trust by the end of the grace period for which your premium is due. Coverage for your spouse will also automatically end on the last day of the month in which any of the following events occur: i) your coverage ends under the Retiree Plan; or ii) your spouse ceases to meet the definition of “Dependent” under the Retiree Plan.

Your spouse who has attained age 65 or who is otherwise eligible for Medicare must enroll in both Parts A and b of Medicare. Your spouse is eligible for enrollment in one of the Medicare Advantage or Medicare Supplement options offered by the Plan. Payment of the applicable monthly premium will be required.

Continued Coverage for a Retiree or Spouse Who Becomes Eligible for Medicare for a Reason Other Than Age

If you or your spouse are properly enrolled in the Retiree Plan and subsequently become eligible for Medicare because of a disability that occurs before age 65, you or your spouse may elect to maintain coverage under the Retiree Plan until you or your spouse reaches age 65. However, you or your spouse must remain continuously covered by Medicare Parts A and B and meet all other qualification criteria established by the Board of Trustees.

Extended Coverage Benefits of Active Plan

Employees and spouses who are disabled on the date of retirement will be required to collect the benefits available to them under the extended coverage provisions of the Active Plan in lieu of the corresponding benefits of the Retiree Plan. The Retiree benefits will not apply until the end of the extended coverage period of the Active Plan.

General Exclusions

Limitations and exclusions under the Retiree Plan are subject to the Medicare Advantage Contracts (Kaiser Permanente/Senior Advantage, Health Net and United Health Care/Secure Horizons) and Insurance Contracts (Hartford Life). Dental Exclusions and Limitations under the Retiree Dental plan are listed in the section entitled "Exclusions and Limitations for the Active and Retiree Dental Plans" on page 56. Exclusions under the Self-Funded Medical Plan are listed on in the section entitled "Exclusions, Limitations and Non-Covered Charges" on page 48.

PRE-FUNDED EARLY RETIREE PLAN (BUE)

PRE-FUNDED EARLY RETIREE PLAN
60 months of coverage for Bargaining Unit Employees between ages 57 and 65
(BARGAINING UNIT EMPLOYEES ONLY)
Effective for eligible Participants retiring on or after January 1, 2002.

Notwithstanding any other provision of this Plan, continued coverage under this Pre-funded Plan requires a determination by the Trustees, in their sole and absolute discretion, before the beginning of every Plan year that the Plan continues to have adequate financial resources to continue this Pre-Funded Early Retiree Plan. Should the Trustees determine that the Plan lacks adequate financial resources to continue this Pre-Funded Plan, you will receive notice of the Trustees' determination by November 1st of the year the determination is made and your coverage will terminate on January 1st of the following year. If your coverage is terminated for this reason, you and your eligible dependents will receive COBRA continuing coverage rights as indicated on page 6 of the Plan.

If at the time you retired you were eligible for coverage under the Plan as an Active Employee and you meet the following requirements, you and your Dependents will be eligible to participate in the Pre-Funded Early Retiree Plan. The Pre-Funded Early Retiree Plan provides for up to sixty (60) consecutive months of coverage for retired Bargaining Unit Employees between the ages of fifty-seven (57) and sixty-five (65) through either the Self-Funded Plan or Kaiser.

Eligibility Rules

You will be eligible for coverage under the Pre-Funded Early Retiree Plan if:

1) You are retired and receiving benefits under I.B.E.W. Local 332 Pension Plan Part A or B;

2) You are between the ages of fifty-seven (57) and sixty-five (65);

3) You have had one hundred and twenty (120) months of coverage in the last one hundred and eighty (180) months under the I.B.E.W. Local 332 Health and Welfare Plan as an Active Employee and were eligible under the Plan immediately prior to your retirement date. Coverage months include coverage earned as a result of employer contributions, self-pay, or coverage earned as a result of reciprocal transfers of employer payments.;

4) You have exhausted your Reserve Bank:

- If you have not used the full sixty (60) months of coverage, but you reach age sixty-five (65), your coverage under the Pre-Funded Early Retiree Plan will terminate. Coverage will also terminate for your spouse regardless of his or her age.

and

5) You must apply to the Pre-Funded Early Retiree Plan through the Plan Administrator.

Effective Date of Coverage

Benefits under the Pre-Funded Early Retiree Plan will begin on the first day of the month following the date in which the Retiree has:

1) Attained age fifty-seven (57);

2) Exhausted his or her Bank Reserve; and

3) Completed an application for participation that has been approved by the Board of Trustees or the Plan Administrator.

Dependent Coverage

Your spouse receives coverage while you are participating in the Pre-Funded Early Retiree Plan regardless of his or her age. Your other Dependents, as defined in the Definition of Terms section of this booklet, can also receive coverage while you are participating in the Pre-Funded Early Retiree Plan. There is a monthly premium or your spouse and/or other Dependents to have coverage. Please contact the Plan Administrator for the current monthly amount.

Notwithstanding the above, coverage for your spouse will automatically end on the date of your divorce or legal separation, or on the first day of the month in which any of the following events occur: i) your spouse reaches age 65; or ii) your spouse is under age 65, eligible for Medicare because of disability and does not remain continuously covered by Medicare Parts A and B; or iii) a monthly premium is not received by the Trust by the end of the grace period for which your premium is due. Coverage for your spouse will also automatically end on the last day of the month in which any of the following events occur: i) your coverage ends under the Pre-Funded Early Retiree Plan; or ii) your spouse ceases to meet the definition of “Dependent” under the Pre-Funded Early Retiree Plan.

Notwithstanding the above, coverage for your Dependents, other than your spouse, will automatically end on the first day of the month in which any of the following events occur: i) a monthly premium is not received by the Trust by the end of the grace period for which your premium is due; ii) your coverage under the Pre-Funded Early Retiree Plan terminates; or iii) your Dependent ceases to meet the definition of “Dependent” as defined in the Definition of Terms section of this booklet.

Your spouse who has attained age 65 or who is otherwise eligible for Medicare must enroll in both Parts A and B of Medicare. Your spouse is eligible for enrollment in one of the Medicare Advantage or Medicare Supplement options offered by the Plan. Payment of the applicable monthly premium will be required.

Continued Coverage for a Retiree or Spouse Who Becomes Eligible for Medicare for a Reason Other Than Age

If you or your spouse are properly enrolled in the Pre-Funded Early Retiree Plan and subsequently become eligible for Medicare because of a disability that occurs before age 65, you or your spouse may elect to maintain coverage under the Pre-Funded Early Retiree Plan until you or your spouse reaches age 65. However, you or your spouse must remain continuously covered by Medicare Parts A and B and meet all other qualification criteria established by the Board of Trustees.

Pre-Funded Early Retiree Plan Benefits

In addition to medical benefits through either the Self-Funded Plan or Kaiser the Trust will provide dental benefits under the Self-Funded Dental Plan for Active and Category 2 Employees and Dependents, vision benefits through the Vision Service Plan, hearing care benefits under the Self-Funded Plan, and chemical dependency benefits through the Beat It! Program.

Termination of Coverage

Coverage in the Pre-Funded Early Retiree Plan will terminate on the last day of the sixtieth (60th) month of coverage or the last day of the month in which you attain age sixty-five (65), whichever is earlier.

After coverage under the Pre-Funded Early Retiree Program terminates, you and/or your Dependents will be eligible for medical, hearing, vision care, and Retiree Dental Benefits under the

Retiree Plan. When Pre-Funded Early Retiree Plan coverage terminates, coverage under the Self-Funded Dental Plan for Active and Category 2 Employees and Dependents terminates.

Examples

A bargaining unit participant retires at age 59 and 2 months with 10 months of coverage in his Bank Reserve. After he exhausts his Bank Reserve, he receives 60 months of free coverage in the Pre-Funded Early Retiree Plan. He attains age 65 the same month his coverage under the Pre-Funded Early Retiree Plan terminates and he moves into one of the Medicare Supplement Plans with the cost of the Supplement Plan subsidized by the Trust.

A bargaining unit participant selected coverage under the Self-Funded Medical Plan. He retires at age 58 with 10 months of coverage in his Reserve Bank. While exhausting the 10 months of Reserve Bank coverage, the participant remains covered under the Self-Funded Medical Plan. After he exhausts his Reserve Bank, the Retiree moves into the Pre-Funded Early Retiree Plan and will receive 60 months of coverage in the Pre-Funded Early Retiree Plan. After 60 months of such coverage, he moves into the Retiree Plan. Since he is not yet eligible for Medicare, he must make a monthly payment to the Plan to help cover the cost of the benefit. When the Retiree attains age 65, he enrolls in Medicare Parts A and B and will move into one of the Medicare Supplement Plans offered by the Trust with the cost of the Supplement Plan subsidized by the Trust.

A participant retires at age 61 with 10 months of coverage in her Reserve Bank. She exhausts her Reserve Bank and is covered under the Pre-Funded Early Retiree Plan. When she turns age 65, even though she has not exhausted the 60 months of coverage under the Pre-Funded Early Retiree Plan, her coverage under the Plan terminates and she must enroll in one of the Medicare Supplement Plans with the cost of the Supplement Plan subsidized by the Trust.

Termination Upon Returning to Active Status:

If you are covered under the Pre-Funded Early Retiree Plan and you return to active status, your coverage under the Pre-Funded Early Retiree Plan will terminate as of the last day of the month in which you return to active status. If you return to active status and subsequently retire, you must apply for the Pre-Funded Early Retiree Plan with the Administrative office.

If you return to active status you must requalify, in accordance with the eligibility requirements of the Active Plan, for coverage under the Active Plan. Self-pay privileges will not be available during any period of lapse in coverage due to returning to active status.

Rules for eligible Participants retiring before January 1, 2002

If at the time you retired you were eligible for coverage under the Plan as an Active Employee and you retired after January 1, 2001, but before January 1, 2002, the above rules do not apply. Please contact the Plan Administrator for a copy of the Plan rules that were in effect on January 1, 2001.

Monthly Premium

There is a monthly premium per person per month for the Pre Funded Early Retiree Plan. The monthly premium amount is subject to change at the discretion of the Board of Trustees. Contact the Plan Administrator for the current monthly premium amount.

RETIREE PLAN (NBUE)

RETIREE PLAN
FOR NON-BARGAINING UNIT EMPLOYEES (NBUE)

Non-Bargaining Unit Employees who have retired from employment in the electrical industry may qualify for the same benefits provided for the Bargaining Unit Employees provided that they fulfill the same participation and other requirements, except for item 1 under Minimum Eligibility Requirements.

In computing the months of coverage under the Plan prior to retirement application, non-bargaining employed participants shall be credited time for months of continuous employment with a signatory employer and prior to a signatory employer coming under the Plan.

All provisions of the Retiree Plan shall apply to this Retiree Plan for Non-Bargaining Unit Employees except Non-Bargaining Unit Employees are not eligible for the Pre-Funded Early Retiree Plan and the required monthly premium amount is different. The required monthly premium per individual is subject to change at the discretion of the Board of Trustees. Contact the Plan Administrator for the current monthly premium amount.

An Employee, who experiences a Total Disability and is under the age of 65, may make self-payments under the Plan for Non-Bargaining Unit Employees at the same rate set forth for this group of Employees until approved for Medicare benefits, at which time the disabled Employee would be eligible for the Retiree Plan.

Kaiser or Self-Funded Plan

All Retirees of the Plan (including Normal, Early and Disabled) who are participants in the Kaiser Permanente or Self-Funded plans at the time of retirement shall be permitted to continue their coverage. Medicare-eligible participants have the same Plan provider options as those provided for the Bargaining Unit Employees under Medicare Advantage plans offered.

RETIREE DENTAL PLAN

RETIREE DENTAL BENEFITS
FOR BARGAINING AND NON-BARGAINING ELIGIBLE RETIREES

Dental Expense Benefits

Retirees and their spouses eligible under the Retiree Health Plan are also eligible for Retiree Dental Benefits through the Self-Funded Plan. If you or your spouse incurs Covered Dental Charges, this Plan will pay at the In-Network benefit level for covered services rendered by preferred provider dentists. Covered dental services incurred at a Non-PPO Dentist will be paid at the Out-of-Network benefit level based on Usual, Customary and Reasonable Charges.

Information regarding preferred provider dentists and Usual, Customary and Reasonable Charges are provided in the "Dental Benefits" section of this Plan booklet.

The In-Network benefit level for Retiree Dental Benefits is one hundred percent (100%) of the Contract Rate for Class I services and, eighty percent (80%) of the Contract Rate for Class II services, and sixty percent (60%) for Class III services. Class II and Class III Services are subject to a FIFTY-DOLLAR ($50) per person /ONE HUNDRED FIFTY DOLLAR ($150) per family per year deductible.

The Out-of-Network benefit level for Retiree Dental Benefits is one hundred percent (100%) of Usual, Customary and Reasonable Charges for Class I Services and, eighty percent (80%) of Usual, Customary and Reasonable Charges for Class II Services and sixty percent (60%) of the Usual Customary and Reasonable Charges for Class III Services. Class II and Class III Services are subject to a FIFTY DOLLAR ($50) per person/ONE HUNDRED FIFTY DOLLAR ($150) per family per year deductible.

Maximum Benefits

Benefits are payable up to a Maximum of ONE THOUSAND DOLLARS ($1,000) per person each calendar year.

Covered Dental Services

"Covered Dental Services" shall be deemed to have incurred on the date the dental service is performed. Covered dental services are organized into three (3) "classes": Class I Diagnostic/Preventive Care, Class II Basic Services and Class III Major Services. The services covered under each Class are listed in the "Dental Benefits" section of this Plan booklet. The Retiree Plan does not provide Class IV Orthodontia Services.

Exclusions and Limitations

Exclusions and Limitations to the Retiree Dental Plan are listed in the "Dental Benefits" section of this Plan Booklet.

DISABLED PARTICIPANTS

1. Health and Welfare Coverage for All Disabled Participants

a. If you become disabled and are unable to work while covered under this Plan, your coverage may be extended without deduction from your reserve bank of dollars and at no cost to you, for up to twelve (12) months (a lifetime maximum). If you prefer, you may use some or all of your reserve bank of dollars before commencing the 12-month free extension. Contact the Plan Administrator's Office to determine the month in which the free coverage will begin.

b. The above will provide you and your eligible Dependents with the same benefits as if you were still employed and at no cost to you.

c. You must provide the Plan Administrator's Office with proof of disability by submitting the completed short-term disability application or a medical claim form with the physician's statement of disability completed by your doctor.

d. If you are still disabled and unable to work after you have used the twelve (12) month free extension, any remaining balance in your reserve bank of dollars will be used to continue your health coverage. You may have a maximum of $20,700 (12 months) in your reserve bank and, of course, you may have less. Contact the Plan Administrator's Office to determine your reserve bank balance and the time period for which your reserve bank will cover you.

2. Health & Welfare Coverage for Disabled Participants Qualified for and Receiving an I.B.E.W. Local 332 Disability Pension Benefit

a. Health and Welfare Coverage under the I.B.E.W. Local 332 Health and Welfare Plan is available for an unlimited number of months on a self-pay basis for disabled participants who meet the following conditions: (1) you are retired under the I.B.E.W. Local 332 Pension Plan (Part A and/or Part B) and (2) you have been insured under the I.B.E.W. Local 332 Health and Welfare Plan for a minimum of sixty (60) months immediately preceding retirement (coverage may either be from self-pay or by working hours for a contributing employer or a combination thereof). Self-payments must commence in the month immediately following the last month of coverage available through active work or reserve hours. Those Employees who do not meet the above qualifications can utilize the self-payment basis explained in the "Self-Payment" section of this Plan booklet. Non-Bargaining Unit Employees must meet all conditions listed above except the pension requirements.

b. Disabled Employees receiving an I.B.E.W. Local 332 disability pension, and under age 62, and not yet eligible for Medicare benefits, may self-pay Health and Welfare premiums for the Plan benefits. You may continue to self-pay until you reach age 62 at which time you may transfer to the Retiree Plan. A disabled Employee may transfer to the Retiree Plan earlier than age 62 if approved for Medicare Benefits and the 60-month requirement as stated in 2a is met.

c. Contact the Plan Administrator's Office for the self-pay premium amount for the Plan benefits.

d. Refer to the "Self-Payment" section of this Plan booklet for further information.

e. Disabled Employees over age 62 may transfer to the RETIREE MEDICAL PLAN. Contact the Administrative Office for the Retiree medical application to do this. The Retiree Plan includes hospital, medical, and vision coverage. It does not include Life Insurance, Accidental Death & Dismemberment, or Short Term Disability coverage. The eligibility requirements are set forth in the "Retiree Plan" section of this benefit booklet.

f. You are eligible for up to ten (10) months of additional free coverage after you have exhausted the 12-month extension and your reserve bank, provided you have had at least ten (10) years of continuous coverage under the Plan immediately prior to the disability, you have obtained a Social Security Disability Award, and you are not yet covered by Medicare. To remain eligible for free coverage, you must elect an HMO option during the first open enrollment period following the commencement of this special extension. The additional period of free coverage ends on the date that you become covered by Medicare based on the Disability Award.

3. Extension of Benefits for Totally Disabled Employees-Medical and Life

a. If you become totally disabled while insured under the Plan, your Health and Welfare coverage will be extended as provided in the "Self-Payment" section of this benefit booklet. Thereafter, should your continuous coverage terminate, you will continue to be eligible for comprehensive medical expenses incurred ONLY FOR THE ILLNESS OR INJURY WHICH CAUSED THE DISABILITY and only for a maximum of twelve (12) months. This additional extension does not cover you for illness or injury not related to the disability and does not provide coverage for your Dependents.

b. Your life insurance remains in effect until you attain age 70 or cease to be totally disabled, provided you became disabled before age 60 and while you were covered under the Active Plan. Coverage may end sooner if the policy terminates or if you fail to provide proof of disability required by the insurance company.

c. Before an extension of benefits is granted, you must have a medical claim form filled out and signed by your doctor attesting to total disability; this must be done annually. The completed medical form is to be given to the Administrative Office medical claims department.

d. The extension of benefits is available at no cost to you.

e. Refer to the "Life Insurance" section for the life insurance extension and to the "Self-Payment" section for the medical extension information.

4. Health and Welfare Benefits for Dependents of a Deceased Disabled Employee or Retiree

a. Upon the death of a disabled Employee covered under the Active Plan, the surviving covered Dependents may continue to purchase coverage for the same time period and with the same limitations as if the Employee had survived, provided that such period equals or exceeds the applicable eligibility period allowed under the COBRA rules in the "Self-Payment" section (Refer to page 6). If an Employee's surviving spouse remarries, coverage for the surviving spouse and Dependent children of the deceased Employee may be continued. Benefits will not be provided to the new husband or wife of the surviving spouse or to any children of that person.

b. Upon the death of a disabled Retiree covered under the Retiree Plan, the surviving spouse may continue to purchase coverage for the same time period and with the same limitations as if the Retiree had survived, provided that such period equals or exceeds the applicable eligibility period allowed under the COBRA rules set forth in the "Self-Payment" section (Refer to page 6). If a Retiree's surviving spouse remarries, coverage for the surviving spouse may be continued. Benefits will not be provided to the new husband or wife of the surviving spouse.

5. Continuing Coverage Following the Accidental Death of a Participant. When a participant dies as a result of a non-occupational accident, health and welfare coverage for the deceased participant's eligible dependents may be extended for up to twelve months at no cost, upon approval by the Board of Trustees. Such extended coverage shall begin only after the deceased participant's reserve bank of dollars has been exhausted. The eligible dependent(s) must

provide the Plan Administrator's Office with a copy of the deceased participant's death certificate before extended coverage can begin.

6. **Hand Control Benefit.** The Plan will pay a lifetime maximum benefit of $750 to provide hand controls for a motor vehicle owned and operated by a disabled participant or an eligible Dependent of a participant. To quality for this benefit, the individual must be (a) continuously covered by the plan from the date the disability commenced to the date the benefit is paid, (b) permanently disabled, and (c) by reason of the disability, unable to operate the vehicle without hand controls. The plan allowance is secondary to any payment available from another source, such as an automobile manufacturer's rebate or allowance for such modifications, other insurance, or recovery from a third party in connection with the illness or injury that caused the disability.

   This benefit is offered on a trial basis and is specifically restricted to the cost of hand controls. It may not be applied to the cost of other vehicle modifications or to any other equipment, materials or supplies. However, a participant or beneficiary who incurs costs for other vehicle modifications necessary to accommodate a permanent disability is encouraged to inform the Trustees to assist them in evaluating this trial benefit. The Trustees may consider expanding the scope of the benefit based on such information, but they are under no obligation to do so.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)
FOR ACTIVE CATEGORY 1 (BARGAINING UNIT), EMPLOYEES
RETIREES AND DEPENDENTS

Effective as of June 1, 2016, a Health Reimbursement Arrangement (HRA) is established for active employees and retirees who are covered by the Plan. The purpose of the Health Reimbursement Arrangement (HRA) is to reimburse Eligible Participants for certain medical care expenses up to the amount of their available account balance.

Questions and Answers

Q-1 What is the Purpose of this Plan?
The purpose of this Plan is to reimburse active employees, retirees, former employees, and their eligible dependents for Eligible Health Care Expenses that are not otherwise covered by the Plan up to the amount of their individual account balance.

Q-2 How Does The Plan Work?
Contributions will be made to your individual Health Reimbursement Arrangement (HRA) account for each hour worked on or after June 1, 2016 that your employer is required under a collective bargaining agreement to make a contribution to the Health Reimbursement Arrangement (HRA) on your behalf. The credited amount will be your account balance. You may use your account balance for the Eligible Health Care Expenses for you and your eligible dependents. Any amounts that you do not use during the calendar year will be rolled over to the next year.

The Board of Trustees reserves the power to assess an administrative charge against each individual Health Reimbursement Arrangement (HRA) account. There is no requirement that investment earnings or interest be allocated to a Health Reimbursement Arrangement (HRA) account inasmuch as the Plan incurs expenses relating to the operation of this benefit. The Trustees may, however, at their discretion, establish an annual earnings allocation to the individual Health Reimbursement Arrangement (HRA) accounts.

The Board of Trustees will provide you with a convenient way to access your Health Reimbursement Arrangement (HRA) account. Benefits will be paid only after an eligible person has incurred an Eligible Health Care Expense, and submitted a claim with supporting documentation. The claim for benefits must be made within one year of the time the expense was actually incurred. The expense must have been incurred on or after June 1, 2016.

Q-3 What is an Eligible Health Care Expense?
An Eligible Health Care Expense is an expense incurred by you or your eligible dependent for medical care as that term is defined in Internal Revenue Code Section 213(d) (generally expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Some common examples of Eligible Health Care Expenses include:

- Premiums for medical insurance under the Plan (including Retiree premiums and COBRA premiums)
- Medications
- Uninsured Medical Expenses (i.e. copayments, coinsurance, deductibles)
- Acupuncture
- Chiropractic expenses
- Contact lenses or glasses used to correct a vision impairment
- Dental Expenses
- Dermatology

- Eye Exams
- Hearing Aids
- Laboratory Fees
- Nursing Services
- Physical Therapy
- Smoking Cessation Programs
- Wheelchairs
- Menstrual care products, including tampon, liner, cup, sponge or similar products used by individuals with respect to menstruation.

Some examples of common items that are not Eligible Medical Expenses include:

- Cosmetic Surgery (Unless necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease)
- Funeral and Burial Expenses
- Household and Domestic Help
- Massage Therapy
- Custodial Care
- Health Club or Fitness Program Dues
- Weight Loss Programs
- Vitamins or Nutritional Supplements

If you need more information regarding whether an expense is an Eligible Health Care Expense under the Plan, contact the Plan's Administration office.

Q-4 How Can I be Reimbursed for an Eligible Health Care Expense?

You will be issued an HRA debit card that can be used to pay for Eligible Health Care Expenses. You can also submit the expense to the Plan Administrator with supporting documentation. Eligible Health Care Expenses may be submitted at any time. Payment of claims will be subject to the regular claims payment procedure of the Plan.

Q-5 Can Participation in the Health Reimbursement Arrangement (HRA) Be Terminated?

Yes. Participation in the Plan for an eligible person will terminate at the following times:

- On the day the Health Reimbursement Arrangement (HRA) is terminated. The Health Reimbursement Arrangement (HRA) is funded only by employer contributions, and is not a vested benefit. This program may be terminated by the Board of Trustees at any time, in which event the Health Reimbursement Arrangement (HRA) accounts shall revert to the general assets of the Plan;
- In the case of a spouse, when a court issues a decree or judgment of legal separation or final dissolution of the active, retired, or former employee and spouse's marriage, or when your participation in the Plan is terminated;
- In the case of a dependent child, when the child no longer meets the requirements to be a dependent child under the Plan or when your participation in the Plan is terminated.

Once participation is terminated, you and your eligible dependents will no longer be eligible for reimbursement from the Health Reimbursement Arrangement (HRA).

Q-6 Can My Participation in This Plan Be Terminated for Cause?

Yes. You and your eligible dependents' participation will be terminated under the conditions set forth below, which constitute termination for cause:

- If you perform any employment of the type covered by the I.B.E.W. Local Union No. 332 Master Labor Agreement for any employer not signatory to a collective bargaining agreement with the I.B.E.W. Local Union No. 332 or another I.B.E.W. Local Union having jurisdiction over the respective geographical area, or engage in business for your own

account without being party to such an agreement, you and your eligible dependents' participation will be terminated on the date of commencement of such employment.

- Your participation in the Health Reimbursement Arrangement (HRA) and the participation of your eligible dependents will terminate immediately in the event you refuse to leave employment after being notified in writing by I.B.E.W. Local Union No. 332 that you must leave employment because your employer is not contributing fringe benefit payments.
- Your participation in the Health Reimbursement Arrangement (HRA) and the participation of your eligible dependents will be terminated immediately in the event you knowingly participate with your employer paying less than the full hourly contract rate of wages and contributions.

If your participation is terminated for cause, your Health Reimbursement Arrangement (HRA) will be canceled and you and your eligible dependents will no longer be eligible for reimbursement from this Plan.

Q-7 What Happens When I Die?

When you die, your individual Health Reimbursement Arrangement (HRA) account can be used to pay for the Eligible Health Care Expenses of your eligible dependents as long as they continue to meet the definition of eligible dependent under the Plan. If you have no eligible dependents remaining after your death, the amount remaining in your individual Health Reimbursement Arrangement (HRA) account will be forfeited to the general assets of the Plan. The Internal Revenue Code prohibits the Plan from paying a death benefit.

Q-8 How Are Health Reimbursement Arrangement (HRA) Contributions Handled If I Am A Traveler Working In This Area, But I Have Reciprocity in Effect?

If you are working under a collective bargaining agreement of I.B.E.W. Local Union No. 332 and you have reciprocity in effect, you will not have an individual Health Reimbursement Arrangement (HRA) account in this Plan. Instead, all contributions made on your behalf shall be reciprocated to your home Local fund, to be allocated at the discretion of the home Local fund's Trustees; however, contributions are noted as health and welfare funds.

Q-9 Can I Waive the Health Reimbursement Arrangement (HRA)?

Yes. You are permitted to permanently opt out of or waive future reimbursement from the Health Reimbursement Arrangement (HRA). If you elect to waive future reimbursement, your individual account shall be forfeited to the general assets of the Plan. Your Health Reimbursement Arrangement (HRA) will not be reinstated at a later time for any reason.

SUMMARY PLAN DESCRIPTION

Information Required by the Employee Retirement Income Security Act of 1974

A. Name of Plan:

This Plan is known as the International Brotherhood of Electrical Workers Local 332 Health and Welfare Trust.

B. Name, Address, and Telephone Number of Joint Board of Trustees:

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

Mailing Address	**Physical Address**
Board of Trustees	Board of Trustees
of the I.B.E.W. Local 332	of the I.B.E.W. Local 332
Health and Welfare Trust	Health and Welfare Trust
P.O. Box 5057	6800 Santa Teresa Blvd. Suite 100
San Jose, CA 95150-5057	San Jose, CA 95119

Telephone: (408) 288-4400

C. Identification Number:

The employer identification number assigned to the Plan sponsor by the Internal Revenue Service is No. 94-6401540. The Plan Number is 509.

D. Type of Plan:

This Plan is a Welfare Plan which provides life insurance, accidental death and dismemberment, short-term disability income coverage, and hospital, surgical and medical, prescription drug, dental and vision benefits.

E. Type of Administration:

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

F. Name, Address, and Telephone Number of Plan Administrator:

Mailing Address	**Physical Address**
Board of Trustees	Board of Trustees
of the I.B.E.W. Local 332	of the I.B.E.W. Local 332
Health and Welfare Trust	Health and Welfare Trust
P.O. Box 5057	6800 Santa Teresa Blvd., Ste 100
San Jose, CA 95150-5057	San Jose, CA 95119

Telephone: (408) 288-4400
Facsimile: (408) 228-4419

G. Name and Address of Agent for Service of Process:

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

George Kraw
Katherine McDonough
Katherine Roselin
Kraw Law Group, a Professional Corporation
605 Ellis Street, Suite 200
Mountain View, CA 94043

H. Names, Titles and Addresses of Joint Board of Trustees:

Labor Organization Trustees:

Daniel Romero
I.B.E.W. Local 332
2125 Canoas Garden Ave.
Suite 100
San Jose, CA 95125

Javier Casillas
I.B.E.W. Local 332
2125 Canoas Garden Ave.
Suite 100
San Jose, CA 95125

Andrew Rogers
I.B.E.W. Local 332
2125 Canoas Garden Ave.
Suite 100
San Jose, CA 95125

Pete Seaberg
I.B.E.W. Local 332
2125 Canoas Garden Ave.
Suite 100
San Jose, CA 95125

Employer Trustees:

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

Vic Castello
Redwood Electric Group
2775 Northwestern Parkway
Santa Clara, CA 95051

Tim Daniels
TDN Electric, Inc.
1071 Wright Ave.
Mountain View, CA 94043

Clinton Woodley
Elcore Electric, Inc.
3310 Bassett Street
Santa Clara, CA 95054

I. Description of Collective Bargaining Agreements:

This Plan is maintained pursuant to the terms of a collective bargaining agreement between the National Electrical Contractors Association of Santa Clara Valley, and other contractors, and the I.B.E.W. Local 332. The collective bargaining agreement provides that employer parties thereto will make the required contributions to this Fund for the purpose of enabling the Employees working under the collective bargaining agreement to participate in the benefits provided by the Trust Fund. Copies of the collective bargaining agreement can be obtained from I.B.E.W. Local 332. You may receive from the Plan Administrator upon written request information regarding whether a particular employer is a Plan sponsor and, if so, the sponsor's address.

J. Eligibility, Termination of Eligibility and Benefits:

This benefit booklet provides a description of benefits, eligibility, and termination of eligibility requirements.

K. Source of Contributions:

This Plan is funded through employer contributions, the amount of which is specified in the underlying collective bargaining agreement or, in the case of Category 2 Agreements, the amount is specified by the Board of Trustees. Also, self-payments by Employees and Dependents are permitted as outlined in the "Self-Payment" section of this booklet. The amount of self-payment is determined by the Board of Trustees from time to time.

L. Organizations Providing Benefits, Funding Media and Type of Administration:

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

Medical, Dental and Time Loss Benefits Under the Active Employee Plan

Claims arising from the self-funded medical and dental plans for employees and dependents and the short-term disability benefits for employees are paid directly from Trust assets.

Preferred Provider Organization

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

Anthem Blue Cross
Anthem Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, CA 91367

Utilization Review Organization

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

Anthem Blue Cross
Anthem Life and Health Insurance Company
21555 Oxnard Street
Woodland Hills, CA 91367

Health Maintenance Organizations

Active Employees, Early Retirees and Eligible Dependents have the option of selecting medical coverage from one health maintenance organizations. The medical benefits are insured and provided under contract between the Trust and Kaiser Foundation Health Plan. Kaiser Foundation Health Plan is responsible for administering their own plans and paying the claims.

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

Mail Order Prescription Drug Program

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

MXP Pharmacy
P.O. Box 32050
Amarillo, TX 79120-2050

Prescription Drug Program

The prescription drug program for Employees and Dependents is provided by MaxorPlus. The Trust is responsible for paying the prescription drug claims. A fee is paid to MaxorPlus for administering the program.

MaxorPlus
320 S. Polk Ste. 200
Amarillo, TX 79101

Vision Plan

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

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

Life and Accidental Death and Dismemberment Insurance

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

The Principal Life Insurance Company
710 9th Street
Des Moines, IA 50392-1502

Substance Abuse Program

Employees and Dependents have access to a substance abuse program provided by Beat It! A fee is paid by the Trust to Beat It! for administering the substance abuse program.

Beat It! Program, Inc.
1798 Technology Drive, Suite 238
San Jose, CA 95110-1399

Podiatry Plan

The podiatry program for employees and dependents is provided by Podiatry Plan of California. A fee is paid by the Trust to Podiatry Plan of California for administering the podiatry program.

Podiatry Plan of California
203 Willow Street, Suite 304
San Francisco, CA 94109-7733

M. Plan Year:

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

N. Statement of ERISA Rights:

As a participant in the I.B.E.W. Local 332 Benefit Plans you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage creases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to One Hundred and Ten Dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act of 1996, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

O. Relationship Between Plan and Providers of Medical Services

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

The foregoing statement applies to any and all health care providers, including both preferred and non-preferred providers under the terms of the Plan. The statement also applies to all entities (and their agents, employees and representatives) which contract with the Plan to offer preferred provider networks or other health-related services or supplies to participants and beneficiaries, including but not limited to, Beat It! Inc., Anthem Blue Cross PPO**,** Kaiser Permanente, Podiatry Plan of California, MaxorPlus, and Vision Service Plan.

P. Plan Amendment and Termination:

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

GENERAL PROVISIONS

Processing and Payment of Claims

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

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

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

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

1. You will be reimbursed for the Plan's share of the cost; or

2. The provider will be reimbursed for the Plan's share of the cost.

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

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

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

The rights, coverage, and eligibility of a participant, employee, beneficiary or dependent under this Plan, or any applicable law, may not be assigned. A direction to pay a provider is not an assignment of any right under this Plan or any legal or equitable right to institute any court or arbitration proceeding.

No action at law or in equity shall be brought to recover on the Plans prior to the expiration of sixty (60) days after proof of loss has been filed, nor shall action be brought at all unless brought within two (2) years from the expiration of the time within which proof of loss is required by the Plan.

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

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

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

2. Part II completed by the attending physician ONLY. (We do not need claim forms completed by the lab technologist, radiologist, or consulting physician.)

    a) Only one claim form is needed for a continuing illness every few months.

b) A new claim form is required for each new illness and each accident.

c) Identify all subsequent bills with your local union name and number.

3. Claims received more than twelve (12) months after the expense is incurred will not be paid unless the Employee provides satisfactory evidence that he/she has remained continuously disabled from the inception of the disability absence through the date the application is received. Any claim for the short-term disability benefit which is not received by the Plan within sixty (60) days of the disability absence will not be paid.

How to File a Dental Claim

1. Obtain a claim form from your Union Office or Plan Administrator.

2. Complete the employee portion of the claim form.

3. Have your dentist complete his/her portion of the claim form.

4. Upon completion of the claim form, attach itemized bills and return your claim form to:

Mailing Address	**Physical Address**
Board of Trustees of the I.B.E.W. Local 332 Health and Welfare Trust P.O. Box 5057 San Jose, CA 95150-5057	Board of Trustees of the I.B.E.W. Local 332 Health and Welfare Trust 6800 Santa Teresa Blvd. Ste. 100 San Jose, CA 95119

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

Claims and Appeals Procedures

Claims should be filed with the Plan Administrator. Contact the Plan Administrator for forms and instructions for making a claim. If the claimant fails to follow the Plan's procedures for filing a claim for benefits, the Administration Office will notify the claimant as soon as possible, but within 5 days following the failure, or if the claim is for urgent care, within 24 hours of failure.

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

   Concurrent Care Claims

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

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

Pre-Service Claims

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

Post-Service Claims

The notice of denial shall be given within thirty (30) days after the claim is filed, unless special circumstances beyond the control of the Plan require an additional 15-day extension of time for processing the claim. If such extension is required you will be sent written notice before the expiration of the initial thirty (30) day period, stating the special circumstances requiring the extension and the date by which a decision on the claim can be expected. If such extension is necessary due to a failure by you to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and you shall be given at least forty-five (45) days from the receipt of the notice within which to provide the specified information. Once the specified information is provided, the Administration Office will notify you of its decision within 15 days.

Disability Claims

All claims and appeals pertaining to disability benefits shall be adjudicated in a manner designed to ensure independence and impartiality of the persons involved in making the determination. Decisions covered by the authority of the Plan regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) making determinations with respect to disability benefits of the Plan will not be made based upon the likelihood that the individual will support the denial of benefits.

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

Urgent Care Claims

The determination as to whether a claim involves urgent care is determined by the attending provider and the Plan defers to such determination. If a claim is for urgent care, the Administration Office will notify you of its determination as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim by the Administration Office. If you fail to provide sufficient information to determine whether benefits are payable under the Plan, then as soon as possible, but no later than 24 hours after receipt of the claim by the Administration Office, the Administration Office will notify you of what information is necessary. You will have 48 hours to provide the specified information. The Administration Office will notify you of its decision as soon as possible, but no later than 48 hours after earlier of (a) the Administration Office's receipt of the specified information or (b) the expiration of the 48-hour period you were given to provide the information.

Claims Subject to *No Surprises Act* Protections
The Plan will make an initial payment or notice of denial of payment for Emergency Services at out-of-network health care facilities, non-emergency services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services within thirty (30) calendar days of receiving a claim from the out-of-network provider or facility that includes all necessary information to decide the claim.

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

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

   Disability Claims
   Written denial of any claim pertaining to disability benefits will include:

   a) a statement of the specific reason(s) for the denial;
   b) reference to the specific Plan provision(s) on which the denial was based;
   c) a discussion of the decision including an explanation of the basis for disagreeing with or not following the views of:
      i. a healthcare professional or vocation professional who treated or evaluated the claimant;
      ii. the views of healthcare professional or vocation professional consulted by the Plan during the claim determination; or
      iii. any disability determination made by the Social Security Administration.
   d) either a copy of the specific internal rules, guidelines, protocols, standards or similar criteria of the Plan relied upon in making the decision or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;
   e) if the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the

determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

f) a description of any additional information or documents that the claimant will need to submit if he or she wants the claim to be reconsidered, and an explanation of why that information is necessary;

g) a description of the Plan's appeal procedures;

h) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and

i) a statement of the claimant's right to bring a civil action under ERISA § 502(a).

3. Review procedure:

a) Where a claim has been denied or partially denied, you may appeal the denial and be given an opportunity for review.

b) Within one hundred and eighty (180) days after you have received written notice that your claim has been denied, you or your representative may make a written request for review to:

I.B.E.W. Local 332 Health and Welfare Plan
P.O. Box 5057
San Jose, CA 95150-5057

Such a written request must include all grounds for appeal and supporting facts.

c) You must submit a written request for review must set forth all the grounds upon which it is based, together with any supporting facts, including comments, documents and records, and any other matters which you feel support your claim, and this information will be considered in determining your appeal.

d) Upon request and free of charge, you may have access to, and copies of, any relevant documents of the Trust or insurance company, including the name of the medical or vocational expert whose advice was obtained in connection with the appeal, without regard to whether the advice was relied upon in making the initial benefit determination.

e) Your appeal will not be reviewed by the same individual who made the initial determination nor a subordinate of such person, and the initial determination will not be given any deference in deciding your appeal.

f) A health care professional with the appropriate training and experience will be consulted in any appeal based in whole or in part on medical judgment, and such health care professional will be neither the health care professional consulted in the initial determination nor the subordinate of such health care professional.

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

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

i) The Board of Trustees has full discretionary authority to interpret all Plan documents and to make all factual determinations concerning your claim. The Board of Trustees has absolute discretion to grant an appeal if, based on the specific facts and circumstances, it is in the best financial interest of the Plan.

j) You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Board of Trustees in connection with the claim; such evidence will be provided as soon as possible and sufficiently in advance to give you a reasonable opportunity to respond before a final determination is made.

k) Before the Board of Trustees issues a final adverse determination on your appeal based on a new or additional rationale, you will be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance to give you a reasonable opportunity to respond before a final determination is made.

4. Decision on review:

Urgent Care Claims

A decision will be made promptly and not later than seventy-two (72) hours after receipt of your request for review.

Pre-Service Claims

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

Post-Service Claims

A decision will be made promptly and not later than 5 days after the meeting of the Board of Trustees that immediately follows your request for review, unless your request was filed within 30 days before the date of such meeting. If so, then a determination will be made no later than the second meeting following the Plan's receipt of request for review. If there are special circumstances that require a further extension of time for processing the request then a determination will be made no later than the third meeting following the Plan's receipt of request for review. In such case, the Plan Administrator will inform you in writing of the extension, describing the special circumstances and the date of when the determination will be made.

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

Disability Claims

A decision will be made promptly and not later than 5 days after the meeting of the Board of Trustees that immediately follows your request for review, unless your request was filed within 30 days before the date of such meeting. If so, then a determination will be made no later than the second meeting following the Plan's receipt of request for review. If there are special circumstances that require a further extension of time for processing the request then a determination will be made no later than the third meeting following the Plan's receipt of request for review. Prior to the commencement of the extension, the Plan Administrator will

inform you in writing of the extension, describing the special circumstances and the date of when the determination will be made.

A notice of denial of a decision on review pertaining to disability benefits will be in writing and will include:

a) the specific reason(s) for the denial;
b) reference to the specific Plan provision(s) on which the denial is based;
c) a discussion of the decision including an explanation of the basis for disagreeing with or not following the views of:
    i. a healthcare professional or vocation professional who treated or evaluated the claimant;
    ii. the views of healthcare professional or vocation professional consulted by the Plan during the claim determination; or
    iii. any disability determination made by the Social Security Administration.
d) either a copy of the specific internal rules, guidelines, protocols, standards or similar criteria of the Plan relied upon in making the decision or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;
e) if the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
f) a statement that the claimant may view and receive copies of documents, records or other information relevant to the claim, upon request and free of charge;
g) the claimant's right to bring a civil action under ERISA § 502(a) within two (2) years after the denial and the calendar date on which the period to bring a civil action expires; and
h) the current contact information for the health insurance consumer assistance or ombudsman.

The Trust Fund Office shall automatically provide to the claimant, free of charge, any new evidence or rationales, if any, as soon as possible and sufficiently in advance of the date on which the appeal determination is to be made in order to give the claimant a reasonable opportunity to address the new evidence or rationale prior to that date. The claimant shall have the right to review and respond to new evidence or rationales considered, relied upon or generated by the Plan in connection with the claimant's claim during the pendency of any appeal.

All notices and disclosures under this section shall .be provided in a culturally and linguistically appropriate manner. The Trust Fund Office will also provide customer service with oral language services in any Applicable Non-English language and provide written notices in any Applicable Non-English language upon request. With respect to an address in any United States county to which a notice is sent, a non-English language is an Applicable Non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

The decision of the Board of Trustees on review shall be final. No lawsuit may be filed without exhausting the above review procedure or showing that the Plan was not compliant with the above procedures, unless the Plan's actions qualify as (i) de minimis; (ii) non-prejudicial; (iii) attributable to good cause or matters beyond the Plan's control; (iv) in context of an ongoing good-faith exchange of information; and (v) not reflective of a pattern or practice of non-compliance. In any such lawsuit, the decision of the Board of Trustees will be subject to judicial review only for abuse of discretion. No legal action may be commenced or maintained against the Trust or Plan more than two (2) years after the claim has been denied.

5. External Review Procedure

(a) **Request for External Review**: You may file a request for an external review with the Plan within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. An adverse benefit determination or final internal adverse benefit determination including those involving medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; the Trustees' determination that a treatment is experimental or investigational; the Trustee's determination whether the Plan is complying with the non-quantitative treatment limitation provisions of ERISA section 712 and § 2590.712), a rescission of coverage, and compliance with the surprise billing and cost-sharing protections under the *No Surprises Act*, are entitled to external review. If there is no corresponding date four months after the date of receipt of a notice, then your request must be filed by the first day of the fifth month following the receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(b) **Preliminary Review**: Within five business days following the date of receipt of the external review request, the Administration Office will complete a preliminary review of the request to determine whether:

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

(2) The adverse benefit determination or the final adverse benefit determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;

(3) You have exhausted the Plan's internal appeal process; and

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

Within one business day of completion of the preliminary review, the Plan will issue a notification to you or your authorized representative informing you whether your claim is eligible for external review. If your request is complete, but not eligible for external review, the notification will include the reasons for ineligibility and contact and support information from the Employee Benefits Security Administration. If the request is incomplete, the notification will describe the information or materials needed to make the request complete, and the Plan will allow you to perfect your request for external review within the four-month filing period or 48 hours of your receiving the notification whichever is later.

(c) **Referral to Independent Review Organization**: The Plan will assign an independent review organization (IRO) that is accredited to conduct an independent external review. The Plan uses three independent review organizations and rotates claims among them to ensure an independent review. The IRO will observe the following procedures:

(1) The IRO will use legal experts where appropriate to make coverage determinations under the Plan.

(2) The assigned IRO will timely notify you of your claim's acceptance for external review. You will be given ten business days to submit additional information to the IRO and the IRO will consider that information in making a determination on your appeal. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

(3) Within five business days after the date of assignment of the IRO, the Plan will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefitdetermination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or adverse final internal adverse benefit determination. Within one business day after making the decision, the IRO will notify you and the Plan.

(4) Upon receipt of any information submitted by you, the assigned IRO must within one business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. The external review be may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day of making such a decision, the Plan will notify you and the IRO and the IRO will then terminate the external review.

(5) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the plan's internal claims and appeals procedure. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision: (a) your medical records; (b) the attending health care professional's recommendation; (c) reports from appropriate health care professionals and other documents submitted by the plan, you, or your treating provider; (d) the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law; (e) appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations; (f) any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the plan or with applicable law and (g) the opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(6) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

(7) The assigned IRO's decision notice will contain: (a) a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider; the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial; (b) the date the IRO received the assignment to conduct the external review and the date of the decision; (c) references to evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision; (d) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision; (e) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or you; (f) a statement that judicial review may be available to you; (g) current contact information for the health insurance consumer assistance or ombudsman.

(8) After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by you, the Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

(d) **Reversal of the Board of Trustees' Decision**: Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

6. **Expedited External Review**: You will be permitted to make a request for expedited external review if you receive (1) an adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to gain maximum function and you have filed a request for an expedited internal appeal; or (2) a final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize the your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but have not been discharged from a facility.

   (a) **Preliminary Review**: Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request is eligible for external review and will immediately send you a notice regarding whether the claim is eligible for external review.

   (b) **Referral to Independent Review Organization**. Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO for review. The plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or by facsimile or by any other expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decision or conclusion reached during the Plan's internal claims and appeal process.

   (c) **Notice of final external review decision**. The assigned IRO will provide notice of the final external review decision, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to you and the Plan.

No Vested Right to Benefits

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

Conditional Payment

If a covered Employee or Dependent has medical expenses as a result of an injury or accident for which a third party is, or may be, held responsible, the Plan may make advance payments on behalf of such Employee or Dependent, subject to the Plan's subrogation rights. Before any such

payments will be conditionally made, the covered Employee or Dependent (or the Dependent's legal guardian if the Dependent is a minor) shall execute an agreement that acknowledges and affirms (1) the conditional nature of the payments and (2) the Plan's rights of subrogation, as provided for below.

Third Party Recovery/Subrogation

This Plan does not cover any illness, injury, disease or other condition for which a third party may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

If a covered Employee or Dependent receives benefits from the Plan arising out of an injury or illness for which the Employee or Dependent (or the guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, such benefit payments shall be made on the condition and with the understanding that this Plan shall be reimbursed in the event the Employee or Dependent recovers from the third party or parties.

If any service is provided or medical claims paid in connection to any injury caused by or involving a third party, and Employee or Dependent receives reimbursement from or on behalf of a third party or from uninsured motorist coverage, the Plan is entitled to recover the full amount of benefits paid under the Plan for such services or claims, up to the gross amount recovered by Employee or Dependent. Upon settlement of the claim or entry of judgment against the third party, insurance company or uninsured motorist coverage, employee or Dependent will pay or cause to be paid to the Plan all amounts to which it is entitled. If an Employee and Dependent receive a settlement or judgment from a third party in an amount which is less than anticipated, this in no way affects the Plan’s right to recover the full amount for claims paid on an Employee’s and Dependent’s behalf.

The Plan has a right to first reimbursement of any recovery from a third party or any uninsured motorist coverage, even if an Employee and Dependent are not otherwise made whole and without regard to how the recovery is categorized. The Employee and Dependent are prohibited from commingling the recovered funds with other assets. An automatic lien will arise in favor of the Plan on any funds recovered from a third party (whether by settlement, judgment, or otherwise) for any illness or injury for which benefits were paid by the Plan. The Employee and Dependent are prohibited from alienating, spending, or distributing any funds so recovered until the Plan has been fully reimbursed for benefits paid. The assets so recovered are owed to the Plan and Employee and Dependent shall be obligated to pay over to the Plan as much of the recovered funds as is required to fully reimburse the Plan for benefits paid. The Plan shall be entitled to enforce this requirement by way of lien, equitable restitution, constructive trust, or any other remedy permitted by law. This Plan will be entitled to recover from the Employee or Dependent any attorney’s fees it incurs in enforcing its recovery rights under this section.

The covered Employee or Dependent shall do nothing to prejudice this Plan’s rights to reimbursement or subrogation, and shall cooperate fully with the Plan in asserting and protecting the Plan’s subrogation rights. The covered Employee or Dependent shall execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect this Plan’s subrogation rights. The covered Employee and/or Eligible Dependents must complete and sign an Agreement to Reimburse in such a form or forms as the Plan may require BEFORE any benefits are paid. If the covered participant and/or Eligible Dependents refuse to sign an Agreement to Reimburse, or any other such agreement the Plan may require, the covered participant and/or Eligible Dependents shall not be eligible for benefits under the Plan for medical claims related to this injury.

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

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

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

Which Plan Pays First?

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

1. Natural parent with whom the child resides.

2. Stepparent with whom the child resides.

3. Natural parent not having custody of the child.

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

A spouse or Dependent who:

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

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

Qualified Medical Child Support Order

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

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

Medicare Coordination of Benefits

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

1. All claims for an Active Employee who is age 65 or older.

2. All claims for Dependents of an Active Employee over age 65.

3. The first thirty (30) months of treatment for end-stage renal disease received by any eligible person who is less than 65 years of age.

Medicare will be primary and this Plan secondary on claims for eligible Employees age 65 or older who do not fall within the above categories with coverage under the Active Plan. This would include retired Employees age 65 or older with extended coverage due to reserve accumulation or making allowable self-payments.

An Active Employee is an individual working in the industry having contributions remitted to the Plan or an individual available for work and on the out-of-work list of I.B.E.W. Local 332 and or an individual on the out-of-work list of I.B.E.W. Local 332 making self-payments for continued coverage. If you are over age 65 and an Active Employee or the spouse of an Active Employee, you may elect Medicare as your primary coverage. If Medicare is elected as primary, medical coverage under this Plan will cease.

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

List of Participating Facilities and Dentists

The Anthem Blue Cross “Prudent Buyer” PPO includes an extensive network of hospitals, physicians and ancillary healthcare providers. The Anthem Blue Cross Dental PPO plan includes a network of participating dentists who have agreed by contract to reduced rates and fee ceilings for both the dental plan and the patient. You can locate a PPO-contracted provider by going to Anthem Blue Cross’s website as noted on page 30. You can locate a Dental PPO-contracted provider by going to Anthem Blue Cross’s website as noted on page 52.

Policies

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

Waiver of Class, Collective and Representative Actions

By participating in the Plan, participants, active employees, employees, retirees, dependents, and beneficiaries waive, to the fullest extent permitted by law, whether or not in court, any right to commence, be a party in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy relating to the Plan, and participants, active employees, employees, retirees, dependents, and beneficiaries agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

Restriction on Venue

A participant or beneficiary shall only bring an action in connection with the Plan in the United States District Court for the Northern District of California.

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Disclosure

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

Restrictions on Use and Disclosure of Protected Health Information

1. The Board of Trustees will not disclose your Protected Health Information, except as permitted or required by the Notice of Privacy and the Privacy Rule, as amended, or required by law.

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

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

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

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

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

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

8. The Board of Trustees will make its internal practices, books, and records, relating to its use and disclosure of your Protected Health Information, available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 C.F.R. § 160-64.

10. The Board of Trustees will, if feasible, return or destroy all your Protected Health Information, in whatever form or medium (including any electronic medium under the Board of Trustees custody or control), received from the Plan, including all copies of any data or compilations derived from and allowing identification of any Participant who is the subject of the Protected Health Information, when your Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all your Protected Health Information, the Board of Trustees will limit the use or disclosure of any of your Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Authorization

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

SECURITY STANDARDS FOR ELECTRONIC PROTECTED HEALTH INFORMATION

1. The Board of Trustees will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan.

2. Adequate separation required by 45 CFR § 164.405(f)(2)(iii) will be supported by reasonable and appropriate security measures.
3. The Board of Trustees will ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information.

4. The Board of Trustees will report to the Plan any security incident of which it becomes aware promptly upon learning of such security incident.

5. The Board of Trustees will make its policies and procedures and documentation relating to these safeguards available to the Department of Health and Human Services for purposes of determining the Plan's compliance with 45 CFR § 164.314(b).

Definitions

Business Associate means a person or entity who provides certain functions, activities or services to the I.B.E.W. Local 332 Health and Welfare Plan involving the use and/or disclosure of Protected Health Information.

Electronic Protected Health Information shall have the same meaning as the term "electronic protected health information" in 45 CFR § 160.103.

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

DEFINITION OF TERMS

Accidental Bodily Injury

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

Active Employee

An active employee is an individual working in the industry having contributions remitted to the Plan or an individual available for work and on the out-of-work list of I.B.E.W. Local 332 or an individual on the out-of-work list of I.B.E.W. Local 332 making self-payments for continued coverage.

AD&D Insurance

Accidental death and dismemberment insurance provided under the group insurance policy with The Principal Life Insurance Company.

Affordable Care Act

Refers to the Patient Protection and Affordable Care Act (P.L. 111-148).

Beneficiary

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

Benefit Booklet

This booklet and any amendments, additions or deletions subsequently made to the Plan.

Benefit Period

Claims incurred for services rendered January through December of a calendar year. A benefit period is established, and begins, when you have incurred during a calendar year covered charges that exceed the deductible amount. All covered charges incurred during a benefit period are used in computing benefit payments. A Benefit Period for an individual ends on the earliest of the following:

1. The last day of the calendar year in which it was established; or
2. The day coverage provided under this Plan ends; or
3. The day the maximum benefit is paid.

Board of Trustees

The individuals who govern the I.B.E.W. Local 332 Health and Welfare Plan.

Category 2 Agreement

A written agreement between the Board of Trustees and a Contributing Employer that allows the Contributing Employer to provide health and welfare benefits to its employees who do not receive benefits pursuant to a collective bargaining agreement.

Chemical Dependency

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

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

Contributing Employer

An employer who is obligated to make health and welfare contributions to the Trust on behalf of employees per a collective bargaining agreement, Category 2 Agreement, or the Santa Clara and San Benito Counties Building and Construction Trades Council pursuant to a participation agreement approved by the Board of Trustees.

Cosmetic Surgery

The surgical alteration of tissue for the improvement of the covered individual's appearance rather than improvement or restoration of bodily function.

Covered Charges

The Usual, Customary and Reasonable Charges or the negotiated rates payable to preferred providers incurred by an eligible person for the medically necessary treatment of conditions covered under the Plan.

Deductible

The amount you pay before the Plan pays benefits. Charges that are not considered covered charges may not be used to satisfy the deductible.

Dependent

Means:

1. An employee's lawful spouse (if not legally separated from the employee). Coverage for the spouse ends on the date of divorce or legal separation unless COBRA coverage is elected. In the event that a married couple are both concurrently covered by the Plan as employees:

    a. Each will also be considered a dependent of the other; and

    b. Each dependent child of such married couple will be considered a dependent of both spouses. However, no more than 100% of covered charges will be paid.

2. An Employee's child who has not reached his or her 26th birthday. A child who is totally or permanently disabled need not meet this age requirement if evidence of disability is furnished to the Trustees within 31 days of the date his/her coverage would have ended due to age. Children who meet the above age requirements and who are named in a Qualified Medical Child Support Order are also dependents. The terms child or children include the Employee's natural children, stepchildren, foster children, legally adopted children and children placed with the Employee for legal adoption.
3. An Employee's registered domestic partner. The following rules and regulations regarding domestic partner coverage apply:

a. A registered domestic partner means an adult with whom the Employee has established a domestic partnership in California by filing a Declaration of Domestic Partnership with the appropriate Sate, City or County agency.
b. The registered domestic partner is entitled to the same benefits that spouses receive.
c. A domestic partner's children are eligible for health coverage under the same conditions as the children of the employee or their spouse.
d. **The cost of coverage for the domestic partner (and each of his or her dependents) is taxable income to you.** The Plan will report the Fair Market Value of your coverage to the Internal Revenue Service each year as taxable income to the Employee. If the Employee believes his or her domestic partner meets the definition of a dependent under the Internal Revenue Code, the Employee may seek a refund from the Internal Revenue Service. The employee is required to remit the additional federal and state income tax, as well as other required payroll taxes to the Trust Fund Office.
e. **Failure to make the necessary payment for domestic partner coverage on time will result in termination of the domestic partner coverage.**
f. If the domestic partnership should end, the Employee must sign and file with the Trust Fund Office a "Dissolution of Domestic Partnership" Form declaring that the domestic partnership has ended and the effective date of the dissolution.

Disability Period

Means a period of time during which an individual is totally disabled. Under the following circumstances, successive periods of total disability due to the same or related causes will be considered one continuous period of total disability:

1. When an Employee has successive periods of total disability which are due to the same or related causes and which are not separated by two or more continuous weeks of active work with an employer; or

2. When a Dependent has successive periods of total disability which are due to the same or related causes and which are not separated by a period of three or more months during which the Dependent is free from total disability which stems from those same or similar causes.

Employee

A person who is working for a Contributing Employer or who is on the out-of-work list of an I.B.E.W. Local Union. The term "employee" also includes an officer, agent, representative or employee of the Union. Effective September 20, 2006, an officer, agent, representative or employee of the Union must also be a Union alumnus to be eligible to participate in the Plan. Union alumnus means a former journeymen or apprentice for whom contributions to the Trust have been made in the past. Effective February 21, 2018, "employee" also includes an employee of the Santa Clara and San Benito Counties Building and Construction Trades Council on whose behalf contributions are made to the Plan pursuant to a written participation agreement approved by the Board of Trustees, provided the employee is a Union alumnus and is not covered by a collective bargaining agreement.

Employer

Any employer with a collective bargaining agreement requiring contributions to the Trust, and any employer making contributions under a written participation agreement approved by the Trustees.

Emergency Medical Condition

The term Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Emergency Service

The term Emergency Service means, with respect to an Emergency Medical Condition (A) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; (B) such further medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital and are required to Stabilize the patient.

Experimental or Investigational Services

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

   The service:

   a. Cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or

   b. Is the subject of a current new drug or new devices application on file with the FDA; or

   c. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service; or

   d. Is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy as among its objectives; or

   e. Is subject to the approval or review of an Institutional Review Board ("IRB") or other body that approves or reviews research concerning the safety, toxicity, or efficacy of services; or

   f. As to the service, the prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that (1) use of the service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity, or efficacy of the service.

2. In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon:

   a. The patient's medical records;

   b. The written protocol(s) or other document(s) pursuant to which the service has been or will be provided;

   c. Any consent document(s) the patient or patient's representative has executed or will be asked to execute, to receive the service;

d. The files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;

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

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

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

Hospital

A facility which:

1. Is licensed (if required) as a hospital;

2. Is open at all times;

3. Is operated mainly to diagnose and treat illnesses on an inpatient basis;

4. Has a staff of one or more doctors on call at all times;

5. Has 24-hour nursing services by Registered Nurses;

6. Is not mainly a skilled nursing facility, clinic, nursing home, rest home, convalescence home or like place; and

7. Has organized facilities for major surgery.

Illness

Means:

1. A disorder or disease of the body or mind;

2. An accidental bodily injury; or

3. Pregnancy.

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

Individual

An employee or one of his/her Dependents. A covered individual means an individual covered under this Plan.

Insurance Company

The Principal Life Insurance Company.

Medical Coverage

Benefits in this Plan other than Life Insurance, Accidental Death & Dismemberment Benefit, Short Term Disability Benefit, Dental, and Vision Benefit.

Medical Necessity

Those services and supplies required for diagnosis and treatment of an illness, injury, mental illness or chemical dependency that, in the judgment of the Board of Trustees:

1. Are consistent with the symptoms or diagnosis and treatment of your condition;

2. Are appropriate with regard to standards of good medical practice;

3. Are not primarily for the convenience of you or a provider of services or supplies;

4. Cannot be left out without adversely affecting your condition; and

5. Are the least costly of the alternative supplies or level of service that can be safely provided to you. This means, for example, that care rendered in a hospital inpatient setting or by a nurse in your home is not medically necessary if it could be provided in a less expensive setting, such as a skilled nursing facility without harm to you.

The fact that a provider may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply medically necessary.

Medicare

Medical benefits provided by Title XVIII of the Federal Social Security Act.

Mental Illness

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

Month

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

Necessary to the Care or Treatment of Illness

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

The treatment, services or supplies must not be:

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

One Continuous Period of Disability.

A period of time during which you are totally disabled. Under the following circumstances, successive periods of total disability due to the same or related causes will be considered one continuous period of total disability:

1. When you have successive periods of total disability that are due to the same or related causes and which are not separated by two or more continuous weeks after being released for active employment by your physician; or

2. When a Dependent has successive periods of total disability that are due to the same or related causes which are not separated by a period of three or more months during which the Dependent is free from total disability that stems from those same or similar causes.

Owner

An "owner" is:

1. A sole proprietor or partner if the business is not incorporated;

2. A shareholder with 10% or more of the stock if the business is incorporated; or

3. The spouse of a person described in 1 or 2 above.

Exceptions: a shareholder or the spouse of an owner may be reclassified as a bargaining unit employee by providing evidence satisfactory to both I.B.E.W. Local 332 and NECA that his/her duties are limited to bargaining unit work and that another person actively operates and controls the business.

Plan Administrator

The Board of Trustees. The Board of Trustees has delegated responsibility for the daily administration of the Plan to United Administrative Services, whose address is 6800 Santa Teresa Blvd., Ste. 100, San Jose, CA 95119.

Preferred Provider

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

Preventive Care

Preventive Care shall include routine health care that includes screenings and patient counseling to prevent illness, disease or other problems and shall include Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved.

Protected Health Information

Individually identifiable health information that is not subject to specific exclusions. The definition of Protected Health Information in 45 C.F.R. §164.501 is adopted for use in the Benefit Booklet.

Provider

1. A licensed Medical Doctor (M.D.).
2. A licensed Doctor of Osteopathy (D.O.).
3. A Chiropractic physician (D.C.) (under certain limited conditions).
4. A Doctor of Medical Dentistry (D.M.D.).
5. A Doctor of Dental Surgery (D.D.S.).
6. A Denturist (under certain conditions).
7. An Optometrist (O.D.).
8. A Doctor of Podiatric Medicine (D.P.M.).
9. A Licensed Clinical Psychologist (PhD).
10. A Clinical Social Worker who:
    a. Has a master's or doctoral degree in social work;
    b. Has at least two years of clinical social work practice;
    c. Is certified by the Academy of Certified Social Workers (ACSW); and
    d. In states requiring license, certification, or registration, is licensed, certified, or registered as a social worker where the services are rendered (LCSW or RCSW).
11. An Audiologist with a Master of Science or Arts and a Certificate of Clinical Competence in Audiology.
12. A Nurse Midwife, who is:
    a. A Certified Nurse Practitioner;
    b. Certified by the American College of Nurse Midwives;
    c. Under the supervision of a qualified physician or hospital; and
    d. Licensed as a Nurse Midwife by the state in which care is rendered (if that state's laws license Midwives).
13. A registered Physical Therapist who is licensed as a Physical Therapist by the state in which care is rendered (if that state's laws license Physical Therapists), for rehabilitative services rendered upon the written referral of a physician.

14. A Speech Therapist who:

    a. Has a master's degree in speech pathology;

    b. Has completed an internship; and

    c. Is licensed as a Speech Therapist by the state in which services are performed (if that state's laws license Speech Therapists).

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

16. A Nurse Practitioner (Certified).

Room and Board Charges

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

Skilled Nursing Facility

A facility qualified as such under Medicare.

Special Charges

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

Speech Therapist

Someone who:

1. Has a master's degree in speech pathology; and

2. Has completed an internship; and

3. Is licensed by the state in which he/she performs his/her services, if that state requires licensing.

Stabilize

The term “stabilized” means, with respect to an Emergency Medical Condition that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, if the Emergency Medical Condition involves a pregnant woman with contractions who cannot be transferred because there is inadequate time to effect a safe transfer to another hospital before delivery, that the woman has delivered (including the placenta).

Summary of Benefits

That part of this Plan outlining the benefits.

TMJ / Temporomandibular Joint Syndrome

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

Total Disability

You will be deemed to have a total disability under the following circumstances:

1. If you are claiming benefits under this Plan, total disability is defined as your inability to work because of illness or injury in your normal job;

2. If a Dependent is claiming benefits under this Plan, total disability is defined as the inability of the Dependent to do the substantial and material duties of a person in similar circumstances who is in good health.

Usual, Customary and Reasonable Charges

Charges normally made by the person, group or other entity rendering or furnishing the services, treatments or materials that fall within the range of charges made by others rendering or furnishing such services, treatments or materials to persons of similar income or net worth within the area in which you normally reside for illnesses or injuries of comparable severity and nature to the illness or injury being treated. As to any particular service, treatment or material, the term "area" means a country or such representative cross section of persons, groups or other entities rendering or furnishing such services, treatment or material to persons of similar income or net worth. If you receive a covered service that costs more than this usual, customary and reasonable charge, the Plan will pay benefits based only on the amount considered usual, customary and reasonable.

Well-Baby and Pediatric Preventive Care:

Well-baby and Pediatric Preventive Care shall include routine health care that includes screenings and patient counseling to prevent illness, disease or other problems and shall include:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the child, adolescent or young adult involved.
- Immunizations for routine use in children, adolescents, and young adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be “in effect” after it has been adopted by the Director of the Centers for Disease Control and Prevention. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

You or Your

The Employee and/or Dependent(s).

APPENDIX OF EXPIRED TERMS

Effective March 27, 2020, if you were employed as a bargaining unit member by a participating employer or on the out-of-work list during February 2020, and have a Reserve Bank with insufficient reserves to continue eligibility under the Plan because of lack of employment on account of impacts of the Coronavirus, you will remain eligible for continued coverage under the Plan for the period of such unemployment through July 31, 2020, or when you return to employment with a participating employer and build a reserve accumulation sufficient to continue coverage under the Plan (whichever occurs earlier). This has to be an involuntary unemployment and you must not have worked in the electrical industry for an employer that does not contribute to a health and welfare plan benefiting workers in the electrical industry under the terms of a collective bargaining agreement after the first contribution is made on your behalf to the Plan.

Effective March 27, 2020, if you were employed as a bargaining unit member by a participating employer or on the out-of-work list during February 2020 and you test positive for the Coronavirus resulting in continued absence from work and have a Reserve Bank with insufficient reserves to continue eligibility under the Plan, you will remain eligible until July 31, 2020, or when you return to employment with a participating employer and build a reserve accumulation sufficient to continue coverage under the Plan (whichever occurs earlier). You must be unable to work due to testing positive for the Coronavirus and you must not have worked in the electrical industry for an employer that does not contribute to a health and welfare plan benefiting workers in the electrical industry under the terms of a collective bargaining agreement after the first contribution is made on your behalf to the Plan.

I.B.E.W. LOCAL 332 HEALTH AND WELFARE PLAN

Board of Trustees

Labor Trustees:	Management Trustees:
Daniel Romero	Doug Lung
Javier Casillas	Vic Castello
Andrew Rogers	Tim Daniels
Pete Seaberg	Clinton Woodley

Plan Administrator

United Administrative Services
6800 Santa Teresa Blvd., Ste. 100
San Jose, CA 95119
Phone: (408) 288-4400

Union

I.B.E.W. Local Union No. 332
2125 Canoas Garden Ave., Suite 100
San Jose, CA 95125

Employee Benefit Plan Consultant

Joseph H. Herrle & Associates, Inc.

Actuary

Northwest Plan Services, Inc.

Legal Counsel

George M. Kraw
Katherine McDonough
Katherine Roselin
Kraw Law Group, a Professional Corporation

Investment Consultants

Segal Marco Advisors

Plan Auditor

Eide Bailly LLP

Corporate Co-Trustee

Matrix Trust Company, a Broadridge Company