IBEW LOCAL 40 – NECA

HEALTH & WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION

SUPPLEMENTAL HEALTH REIMBURSEMENT (HRA) PLAN

Caution: This document is a brief summary only of the pertinent provisions of the Supplemental Health Reimbursement Account Plan. This document is called a Wrap-around SPD. Attaching this document to the complete HRA Plan document will constitute a complete Summary Plan Description. A copy of the complete HRA Plan document is available from Coast Benefits, who are the administrators of the Plan. You can contact Coast Benefits at 619-280-2009 or toll-free at 800-886-7559 if you have any questions regarding this Plan

CONTENTS

SUMMARY PLAN DESCRIPTION
GENERAL INFORMATION

ADMINISTRATIVE OFFICE

IBEW LOCAL 40 - CAL STEALTH AND WELFARE TRUST FUND

Coast Benefits
3444 Camino Del Rio North, Suite 106
San Diego, CA 92108
(800) 886-7559

OFFICE HOURS:

Monday - Friday, 8:00 a.m. – 5:00 p.m., Excluding Holidays

BOARD OF TRUSTEES

LABOR TRUSTEES:

Bill Brinkmeyer
Jerry McLinn
Dave Grabowski

MANAGEMENT TRUSTEES:

Jim M. Willson
Michael E. Richards
Henry Turner

ADMINISTRATOR

Jonnette Tucker
Coast Benefits

LEGAL COUNSEL

Melissa Cook, Esq
Cook & Associates

CONSULTANT

Gerald Lutzker & Associates, Inc.
Garner Consulting

ASSISTANCE

This booklet contains a summary of your Plan rights and benefits under the IBEW Local 40 - NECA Health and Welfare Plan.

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

Coast Benefits
3444 Camino Del Rio North, Suite 106
San Diego, CA 92108

Telephone:	(800) 886-7559
Fax:	(619) 280-4304
Office Hours:	Monday-Friday, 8:00 a.m. – 5:00 p.m., Excluding Holidays

GOVERNING BENEFIT DOCUMENTS

The extent of each active Employee's benefits is governed by the complete terms of the contracts issued to the Fund by the Kaiser Foundation Health Plan, DeltaCare and any rules and regulations that the Trustees may adopt from time to time. This booklet describes these benefits in general terms. If there is any difference between this booklet and the Plan contracts issued by any of the above providers, the terms and conditions of the Contracts shall prevail. These documents are available for inspection at the Administrative Office.

KEEP YOUR RECORDS CURRENT

Notify the Administrative Office immediately in writing of any change of address or if you have a change of dependents.
For example:

- You get married
- You have a new baby
- You get divorced
- You adopt or become a legal guardian of a child

Refer to the section entitled, "Eligible Dependents," for further information.

LETTER OF INTRODUCTION

To: All Local 40 Active Employees and Their Eligible Dependents

Welcome to the IBEW Local 40-NECA Supplemental Health Reimbursement Account, called HRA for short.

The benefits for medical care described in this SPD have been designed to supplement the hospital, medical and dental benefits available to Participants of the IBEW Local 40–NECA Health Plan plus provide reimbursement for eligible expenses not covered elsewhere.

Effective with December 2006 hours, employer contributions began to fund the IBEW Local 40-NECA Supplemental Health Reimbursement Account (HRA) Plan. Employees who are participants in the Plan have established individual accounts based on the employer contributions paid on your behalf for each hour you work in Covered Employment.

Effective January 1, 2009, monies in each individual account are being transferred to Putnam Investments. Each month that the Administrative Office receives employer contributions paid on your behalf the monies will be sent to Putnam Investments for allocation to your HRA.

The monies in your HRA will accumulate including any investment earnings, on a tax-free basis. A portion of the employer contributions may be used to reimburse you and your eligible dependents for qualified medical expenses while you are covered as an active employee under this Plan. The allocation (percentage split) of employer contributions for active Employees has been established at 50% and may be periodically reviewed and amended by the Board of Trustees.

The balance of the employer contribution allocation has been established at 50%. These monies will be held on your behalf and will be available for you and your eligible dependents for qualified medical expenses after you retire.

We believe the HRA will be beneficial for you and your eligible dependents in paying for Eligible Expenses not covered elsewhere.

This Plan has been established on your behalf. If you have any questions, contact the administrator, Coast Benefits at 619-280-2009 or toll-free at 800-886-7559 during regular weekday office hours from 8 a.m. to 5 p.m., excluding holidays.

Sincerely,

Board of Trustees
January 1, 2009

DEFINITIONS

GENERAL PLAN DEFINITIONS

ASSOCIATION

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

COLLECTIVE BARGAINING AGREEMENT

Any Agreement between NECA and IBEW Local Union 40, which requires contributions into this Trust Fund.

CONTRIBUTION

The payment made or to be made to the Trust Fund by any Individual Employer under the provisions of any of the Collective Bargaining Agreements. The term "Contribution" shall also include a payment made on behalf of an Employee of a Local Union pursuant to regulations adopted by the Board of Trustees.

COVERED EMPLOYMENT

Work as an Electrician at a job covered by the Collective Bargaining Agreement between NECA and IBEW Local Union 40.

DEPENDENT

This is as defined in this SPD booklet. Refer the section entitled, "Eligible Dependents."

ELECTRICIAN

Includes any Employee who works in any classification covered by a Collective Bargaining Agreement requiring contributions to this plan, negotiated between the Los Angeles Chapter of NECA and IBEW Local Union 40.

ELIGIBLE EMPLOYEE

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

ELIGIBLE EXPENSES

Expenses eligible for reimbursement under this Plan for qualified medical expenses as defined by the Internal Revenue Service (IRS).

EMPLOYER

Any individual Employer signatory to an Agreement with the Union and the Association that requires contributions by the Employer into this Trust Fund. The term "Employer" also includes the Union.

PARTICIPANT

The term "Participant" applies to all Employees and Retirees who are eligible for benefits under this Plan.

RETIREMENT

Age 55 and termination of employment in the industry for a period of 12 months

SPOUSE

The Participant's legal husband or wife.

TRUSTEE AND/OR BOARD OF TRUSTEES

As defined in the Agreement and Declaration of Trust establishing the IBEW Local 40 - NECA Health and Welfare Trust Fund.

UNION AND/OR LOCAL UNION

The International Brotherhood of Electrical Workers (IBEW), AFL-CIO, Local 40.

ALL YOU NEED TO KNOW ABOUT USING YOUR HEALTH REIMBURSEMENT ACCOUNT CARD

1. You must activate your HRA card before you use it. To activate your card, simply call 1-866-363-4128.

2. Use your card for eligible health-care expenses only. A list of current eligible IRS expenses is contained in the section entitled "Health Care Expenses" that follows. This card can only be used in places where health-care products and services are likely to be sold.

3. Do not use your card to pay for past services received prior to becoming a Participant or future services not yet incurred. The IRS prohibits you from using this card to pay for services you received before you are a Participant or those you plan to receive in the future and have not yet incurred.

4. Each time you use your card, you authorize that you are paying for eligible health-care expenses incurred by you or an eligible dependent and that you have not and will not seek reimbursement for these expenses from any other health plan or source.

5. Save all receipts that describe exactly what you paid for with your card. We may ask you to submit receipts to show you used your card for eligible health-care expenses.

6. Debit or credit? Choose credit. Even though this is not a credit card, choose the credit option. Your card has no PIN.

7. Review your monthly statements. You should verify the purchases you made using the card for accuracy.

8. You are required to reimburse your account in the amount of any card purchase if you cannot show the card was used for eligible health-care products or services. Your HRA card is a prepaid card that can be used at most merchants who sell health-care products or services and

accept VISA debit cards. A Member Financial Institution of Visa USA issues the card.

There is no minimum dollar amount that you can charge on your card. Obviously, in using your card you cannot exceed the amount of money in your account for any eligible medical expense subject to the following proviso.

Your individual HRA account with Putnam Investments requires that you must maintain a minimum balance of $200 in your individual HRA account. In other words, the debit card is built to exclude the final $200 of a participant's account. This is done to ensure that there are no issues with market fluctuation of account adjustments that result in paying out money on the debit card that the participant doesn't actually have.

How to Order Additional Cards

1. Log on to www.benefitcenter.com

2. Click on the HRA tab

3. Select Request Additional Card

4. Provide first name, last name and Social Security number of the person who will use the card.

- The first additional card is provided free of charge.
- There is a charge for the second additional card.
- No more than three cards are available per account (one for you, the member, as well as two for use by your eligible dependents).

Your Health Reimbursement Account Web Site

Manage your account and get help conveniently online.

- You can do all this online anytime:
- View your account activity and balance
- Check status of claims and payments
- Download claims forms
- Get help
- Request Pay My Provider payments
- Order an additional card

If you have not yet registered, complete the simple online HRA registration process.

1. Go to http://www.ibenefitcenter.com
2. Click on the HRA tab
3. Click on First Time User? Register Now.
4. Enter the information requested so we can identify you.
5. Review the User Agreement and confirm your acceptance

If you have already registered:

Go to http://www.ibenefitcenter.com and click on the HRA tab. Enter your user name and password.

IF YOU DON'T HAVE INTERNET ACCESS

You can call your plan's toll-free number, 1-877-UNION-44, 24 hours a day, seven days a week. Select Health Reimbursement Account if you are prompted and press two for claims-related inquiries.

Customer service representatives are available during normal business hours if you require personal assistance.

THE HRA CARD

Pay for eligible items at the point of sale with your card and funds are deducted automatically from your HRA.

WHY USE THIS CARD?

- No claims to file, no need to get reimbursed
- Works like a credit card
- Deducts automatically from your HRA account
- Most convenient way to pay for most eligible health-care products and services.

WHEN TO USE THE CARD

- Pay for eligible health-care expenses incurred by you or an eligible dependent
- The IRS prohibits you from using this card to pay for services when you are not covered under the plan

- Once all of the funds in your account have been used you will be unable to use your card until your individual account has been replenished by employer contributions as a result of your working in Covered Employment.

WHERE TO USE THE CARD

- Doctor and dentist offices
- Pharmacies
- At most merchants who sell health-care products or services and accept Visa debit cards

IF YOU LOSE YOUR CARD OR IF IT IS STOLEN:

Contact Putnam immediately at your plan's toll-free number, 1-877-UNION-44. Select Health Reimbursement Account if you are prompted and press 2.

Customer services representatives are available during normal business hours if you require personal assistance.

HRA PAY MY PROVIDER

Pay your providers or insurance plan directly from your HRA.

WHY USE PAY MY PROVIDER

- No claims to file; no need to get reimbursed
- Works like a bill-pay service
- Deducts automatically from your HRA
- Most convenient way to pay for most recurring eligible health-care services, including monthly/quarterly health insurance premiums

WHEN TO USE PAY MY PROVIDER

- Regularly scheduled payments for eligible expenses such as orthodontic care or physical therapy
- Balance billing, which is when your provider bills your health plan and then bills you for the amount your health plan does not cover
- Invoices you receive after the date of service for eligible expenses that require only basic proof of service
- Your payment is $20 or more

HOW TO PAY MY PROVIDER:

1. Log on to http://www.ibenefitcenter.com*
2. Click on HRA tab
3. Click Request Pay My Provider
4. Confirm or enter your email address
5. Enter your provider information
6. Enter patient information
7. Enter your payment amount(s)
8. WageWorks will make the requested payment(s) from your account and mail it directly to your provider.

*If you do not have Internet access, call 1-877-UNION-44 for paper form requests.

HRA PAY ME BACK

Get reimbursed from your HRA for eligible expenses you pay out of pocket

WHEN TO USE PAY ME BACK:

Some expenses are easier to pay and then get reimbursed. For example:

- You must pay in advance. Pay for the services as required and then file your claim once you have received the service.
- Your provider does not accept Visa
- The expense is listed as a Maybe in the HRA Expense list and requires additional information in order to be approved.
- You receive a bill from your provider after your health plan pays and your portion is less than $20, the minimum Pay My Provider payment amount.

HOW TO PAY ME BACK:

- Pay for your eligible expense as you usually do and save your detailed receipt
- Complete an HRA Pay Me Back form. Forms can be downloaded from your plan's web site:

    1. Log on to http://www.ibenefitcenter.com
    2. Click on the HRA tab
    3. Select the Print Forms page

Fax your form and proof of expense to the number indicated on the form. Or, mail your form and photocopies of your proof of expense to the address indicated on the form.

PROOF OF EXPENSE

BASIC

You must provide proof for each expense listed on your Pay Me Back claims form. Your proof should be appropriate for the type of expense.

- Pharmacy receipt for prescriptions and other pharmacy purchases
- Doctor's office receipts for office visit
- Explanation of Benefits (EOB) from your insurance or health plan, for covered medical and dental expenses
- Bill or invoice from doctor or dentist for expenses not covered by your insurance or health plan
- Payment contract, monthly payment coupon or statement from your orthodontist
- Receipt from your optometrist or other medical service provider

BASIC +

Same as Basic but with a written statement from your provider indicating (1) the diagnosis and (2) the medical necessity of the expense.

BASIC ++

Same as Basic + but with proof of difference in cost: (1) the cost of standard, unmodified item, and (2) the cost of special or modified item.

The reimbursable amount is the difference between these two.

HRA RULES

The following rules are required by IRS regulations:

1. Your account can be used to pay for eligible expenses incurred while you are eligible for benefits in the plan. Expenses are considered incurred on the day of service, not when you are billed or pay.

2. Your account cannot be used to pay for expenses incurred while you are not eligible for benefits under the plan.

3. Your account can only be used to pay for medically necessary and eligible health-care expenses for which you have not and will not seek reimbursement from any other health plan or source.

4. Each time you use the card, you authorize that you are paying for eligible expenses incurred by your or an eligible dependent while you are eligible for benefits.

5. You cannot take a deduction or a tax credit on your tax return form for any health-care expense paid for through this account.

6. You are responsible for maintaining documentation (e.g., detailed receipts) to verify your expenses (the nature of each expense, the amount and the date incurred). Keep it with your other important tax papers for the calendar year. You may be requested to submit the documentation per your monthly statement.

QUESTIONS?

You can call your plan's toll-free number, 1-877-UNION-44, 24 hours a day, seven days a week. Select Health Reimbursement Account if you are prompted.

Customer service representatives are available during normal business hours if you require personal assistance.

GENERAL PROVISIONS

INITIAL ELIGIBILITY

Each Participant on whose behalf employer contributions are made to this Plan for hours worked on or after December 1, 2006 will become a Participant of this Plan. The Spouse and the Dependents of the Participant will also be covered.

The term "Dependents" includes the Participant's unmarried children under nineteen (19) years of age but excludes any person otherwise eligible for coverage under the Plan as a Participant. Such Dependents include (1) a blood descendant of the first degree, (2) a legally adopted child (including a child living with the adopting parents during the period of probation), (3) a stepchild residing in the Participant's household, or (4) a person under nineteen (19) years of age permanently residing in the household of which the Participant is the head of such person is actually being supported solely by the Participant, and the Participant is related to the person by blood or marriage or is the person's legal guardian. To be eligible for Dependent coverage, proof may be required that the Dependent comes within the foregoing definition.

The term Dependent also includes a Participant's unmarried child who is over nineteen (19) years of age but less than twenty-four (24) years of age if the child is solely dependent on the Participant and is attending school on a full-time basis. Status as a full-time student must be verified each year.

If a Participant's child is born after the Participant's death, that child may be covered as a Dependent while coverage for the Participant's other Dependents is in force.

RECIPROCITY RULE

If you work outside the jurisdiction of the Plan and you elect to have your contributions reciprocated (i.e., forwarded to this Plan). All reciprocity contributions received by the Plan will first be applied to the current contribution required for coverage under the IBEW Local 40 NECA Health and Welfare Trust Fund and any excess will go to your HRA account.

Continuation of Coverage for Disabled Children

If a Participant has an unmarried child who is chiefly dependent upon the Participant for support and maintenance and the child is incapable of self-sustaining employment by reason of mental illness, developmental disability or physical handicap and the child became so incapable of self-sustaining employment prior to attaining the age at which coverage would otherwise terminate, the child's coverage under this Plan will be continued as long as the child remains incapable of self-sustaining employment and the Participant's coverage continues under this Plan or, if sooner, the date on which the child no longer meets the Plan's definition of a child for any reason except the age or residence of the child.

In order, however, for the coverage of such child to continue past the age at which Dependent coverage would otherwise terminate, the Participant must continue to be a Participant in this Plan and submit proof that the child is and continues to be incapable of self-sustaining employment by reason of one or more of the conditions mentioned above and that the child is unmarried and is chiefly dependent upon the Participant for support and maintenance. The Participant must supply this proof within thirty-one (31) days after the dependent's coverage as a dependent would otherwise have ceased and when requested thereafter by the Plan Office.

Death of a Participant

If a Participant dies with an Account Balance in the Plan, claims for benefits under the Plan received from the Participant's Spouse and/or Dependents subsequent to the Participant's death will be paid from the Account Balance until the balance is reduced to zero.

Plan Assets and Earnings

The Trustees shall invest and reinvest the assets of the Plan in such investments from time to time, as they deem appropriate after taking into consideration the probable distribution rate of those assets.

All income earned on such Plan Assets shall be used to pay Plan expenses and any remaining income shall periodically be allocated on a per capita basis to the Accounts of all Participants of the Plan on the date of allocation including the Accounts of any Participants who have died leaving a Spouse or Dependents who are eligible to obtain reimbursement from the deceased Participant's remaining Account Balance at that time.

HEALTH-CARE EXPENSES

You can pay for eligible expenses that require Basic proof using your HRA card, Pay My Provider or Pay Me Back. For expenses requiring more than Basic proof, you will need to use an alternative payment method and then file a Pay Me Back claim to get reimbursed.

The following is a list of permissible expenses that may be reimbursed out of this Plan beginning January 1, 2009:

- **Abortion**
- **Acupuncture**
- **Alcoholism** – inpatient treatment at a therapeutic center for alcohol addiction, including treatment and lodging provided by the center during treatment; amounts paid for transportation to and from Alcoholics Anonymous meetings in your community if the attendance is pursuant to medical advise that membership in Alcoholics Anonymous is necessary for the treatment of a disease involving the excessive use of alcoholic liquors.
- **Ambulance**
- **Artificial Limb**
- **Artificial Teeth**
- **Autoette**
- **Bandages**
- **Breast Reconstruction Surgery** – following a mastectomy for cancer.
- **Birth Control Pills**
- **Braille Books and Magazines** – the part of the cost of Braille books and magazines for use by a visually impaired person that exceeds the cost of regular printed editions
- **Capital Expenses** – amounts paid for special equipment installed in a home, or for improvements, if their main purpose is medical care for you, your spouse, or your dependent; the cost of the permanent improvements that increase the value of your property may be partly included as a medical expense; the cost of the improvement is reduced by the increase in the value of your property. Certain improvements did not usually increase the value of a home and can be included in full as medical expenses including, but not limited to:
    - Constructing entrance or exit ramps for your home

- Widening doorways at entrances or exits to your home
- Widening or otherwise modifying hallways and interior doorways
- Installing railings, support bars, or other modifications to bathrooms
- Lowering or modifying kitchen cabinets and equipment
- Moving or modifying electrical outlets and fixtures
- Installing porch lifts and other forms of lifts (but elevators generally add value to the house)
- Modifying fire alarms, smoke detectors, and other warning systems
- Modifying stairways
- Adding handrails or grab bars anywhere (whether or not in bathrooms)
- Modifying hardware on doors
- Modifying areas in front of entrance and exit doorways
- Grading the ground to provide access to the residence
- Car – the cost of special hand controls and other special equipment installed in a car for the use of a person with disability; the price difference between the cost of a regular car and a car specially designed to hold a wheelchair

- **Chiropractor**
- **Christian Science Practitioner**
- **COBRA Continuation Health Coverage**
- **Contact Lenses** – needed for medical reasons, including the costs of equipment and materials required for using contact lenses, such as saline solution and enzyme cleaner
- **Crutches**
- **Dental Treatment** – including x-rays, fillings, braces, extractions, dentures, etc., but not including teeth whitening
- **Diagnostic Devices**
- **Disabled Dependent Care Expenses**
- **Drug Addiction** – inpatient treatment at a therapeutic center for drug addiction, including meals and lodging at the center during treatment
- **Drugs**, see **Medicines**
- **Eyeglasses** – needed for medical reasons, including fees paid for eye examinations
- **Eye Surgery**
- **Fertility Enhancement**

- **Guide Dog or Other Animal** – the costs of buying, training, and maintaining a guide dog or other animal to assist a visually-impaired or hearing-impaired person, or a person with other physical disabilities
- **Health Institute** – treatment at a health institute only if the treatment is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness of the individual receiving the treatment
- **Health Maintenance Organizations (HMO)** – out-of-pocket expense
- **Hearing Aids**
- **Home Care**, see **Nursing Expenses**
- **Home Improvements**, see **Capital Expenses**
- **Hospital Services**
- **Insurance Premiums** – insurance premiums *you* pay for policies that cover *medical care*
- **Laboratory Fees**
- **Lead-Based Paint Removal** – the cost of removing lead-based paints from surfaces in your home to prevent a child who has or has had lead poisoning from eating the paint; these surfaces must be in poor repair (peeling or cracking) or within the child's reach (the cost of repainting the scraped area is not a medical expense); if, instead, the area is covered with wallboard or paneling, treat as a capital expense (the cost of paining the wallboard is not included as a medical expense)
- **Learning Disability**, see **Special Education**
- **Legal Fees** – necessarily incurred to authorize treatment for mental illness; cannot include fees for the management of a guardianship estate, fees for conducting the affairs of the person being treated, or other fees that are not necessary for medical care
- **Lifetime Care** – Advance Payments – e.g. under an agreement with a retirement home
- **Lodging** – provided during medical treatment services
- **Long-Term Care Contracts**, Qualified
- **Meals** – provided during medical treatment services
- **Medical Conferences** – amounts paid for admission and transportation to a medical conference if the medical conference concerns the chronic illness of yourself, your spouse, or your dependent; the costs of the medical conference must be primarily for an necessary to the medical care or you, your spouse, or your dependent; the majority of the time spent at the conference must be spent attending sessions on medical information

- **Medical Information Plan** – amounts paid to a plan that keeps medical information in a computer data bank and retrieves and furnishes the information upon request to an attending physician
- **Medical Services** – amounts paid for legal medical services provides by physicians, surgeons, specialists, or other medical practitioners
- **Medicines** – amounts paid for prescribed medicines and drugs; a prescribed drug is one that requires a prescription by a doctor for its use by an individual; you can also include amounts paid for insulin; except for insulin, you cannot include in medical expenses amounts you pay for a drug that in not prescribed
- **Mentally Retarded, Special Home for** – the costs of keeping a mentally retarded person in a special home, not the home of a relative, on the recommendation of a psychiatrist to help the person adjust from life in a mental hospital to community living
- **Nursing Home** – the cost of medical care in a nursing home, home for the aged, or similar institution, for yourself, your spouse, or your dependents, including the cost of meals and lodging in the home if a principal reason for being there is to get medical care
- **Nursing Services**
- **Operations** – amounts paid for legal operations that are not for unnecessary cosmetic surgery
- **Optometrist**, see **Eyeglasses**
- **Organ Donors**, see **Transplants**
- **Osteopath**
- **Oxygen** – amounts paid for oxygen and oxygen equipment to relieve breathing problems caused by a medical condition
- **Prosthesis**, see **Artificial Limb**
- **Psychiatric Care**
- **Psychoanalysis**
- **Psychologist**
- **Special Education** – fees paid on a doctor's recommendation for a child's tutoring by a teacher who is specially trained and qualified to work with children who have learning disabilities cause my mental or physical impairments, including nervous system disorders. You can include in medical expenses the cost (tuition, meals, and lodging) of attending a school that furnishes special education to help a child to overcome learning disabilities; a doctor must recommend that the child attend the school and overcoming the learning disabilities must be a principal reason for attending the school; special education includes teaching Braille to a visually impaired person, teaching lip

reading to a hearing impaired person, or giving remedial language training to correct a condition caused by a birth defect.

- **Sterilization**
- **Stop-Smoking Programs** – does not include drugs that do not require a prescription, such as nicotine gum or patches, that are designed to help stop smoking
- **Surgery**, see **Operations**
- **Telephone** – the cost of special telephone equipment that lets a hearing-impaired person communicated over a regular telephone
- **Television** – the cost of equipment that displays the audio part of television programs as subtitles for hearing-impaired persons
- **Therapy** – received as medical treatment
- **Transplants**
- **Transportation** – amounts paid for transportation primarily for, and essential to, medical care
- **Trips** – amounts paid for transportation to another city if the trip is primarily for, and essential to, receiving medical services
- **Tuition** – in special circumstances: see Special Education; charges for a health plan included in a lump-sum tuition fee if the charges are separately stated or can easily be obtained from the school
- **Vasectomy**
- **Vision Correction Surgery**
- **Weight-Loss Program** – if it is a treatment for a specific disease diagnosed by a physician (such as obesity, hypertension, or heart disease); this includes fees you pay for membership in a weight reduction group and attendance at periodic meetings; this does not include membership dues in a gym, health club, or spa as medical expenses, or the cost of diet food or beverages
- **Wheelchair** – used mainly for the relief of sickness or disability
- **Wig** – purchased upon the advice of a physician for the mental health of a patient who has lost all of his or her hair from disease
- **X-ray**

EXCLUDED EXPENSES

The following is a list of items that are not eligible for reimbursement under this Supplemental HRA Plan:

- Baby Sitting, Childcare, and Nursing Services for a Normal, Healthy Baby
- Controlled Substances
- Cosmetic Surgery
- Dancing Lessons
- Diaper Service
- Electrolysis or Hair Removal
- Flexible Spending Account
- Funeral Expenses
- Future Medical Care
- Hair Transplant
- Health Club Dues
- Health Coverage Tax Credit
- Health Savings Accounts
- Household Help
- Illegal Operations and Treatments
- Insurance Premiums- other than premiums you pay for policies that cover medical care.
- Maternity Clothes
- Medical Savings Account (MSA)
- Medicines and Drugs From Other Countries
- Nonprescription Drugs and Medicines
- Nutritional Supplements
- Personal Use Items
- Swimming Lessons
- Teeth Whitening
- Veterinary Fees
- Weight-Loss Program- other than as provide for above.

COBRA PREMIUMS

COBRA premiums for continuation coverage under the Health Plan is a permissible expense that may be paid out of the Plan. To have COBRA premiums paid from the Plan you must make an election on a form and submit to the Plan office. When there are insufficient funds available to make any such payments that may become due, the Plan office shall notify the Participant of the insufficient funds. In the event of the death of the Participant, the Participant's Spouse and/or Dependents may elect to pay their COBRA premiums for continuation coverage to the Plan.

RETIREE COVERAGE COSTS

One-half of all employer contributions into this Supplemental HRA Plan will be set aside and used for the sole and exclusive purpose of paying for retiree coverage for the Participant.

The Board of Trustees reserves the right in their sole and absolute discretion to modify the designated percentages of the allocation of employer contributions between active employees and retired employees' accounts.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

A complete copy of the HIPAA Notice is contained in the Supplemental Health Reimbursement Account Plan Document a copy of which may be obtained by contacting the Administrative Office.

INFORMATION REQUIRED UNDER ERISA

The Employee Retirement Income Security Act of 1974

***Plan Name**:* IBEW Local 40–NECA Supplemental HRA Plan

Identification Number: 95–4660513

Plan Number: 002

Type of Plan: An individual account plan which provides for the reimbursement of various hospital, medical, dental, vision care and other medical expenses including retiree benefits that are required to be paid by the individual Participant, Spouse or Dependent in order to obtain certain benefits under the Health Plan.

Plan Year: November 1 through October 31.

Plan Sponsors: The Los Angeles Chapter of the NECA and IBEW Local 40. The Board of Trustees of the IBEW Local 40-NECA Health Trust Fund administers the Plan. This plan is maintained pursuant to one or more collective bargaining agreements. A copy of the agreement may be obtained by participants and beneficiaries upon written request to the plan administrator and is available for examination at the offices of the plan administrator.

Names and addresses of the Trustees:

Labor Trustees **IBEW Local 40**	**Management Trustees** **NECA**
Bill Brinkmeyer IBEW Local Union 40 5643 Vineland Avenue North Hollywood, CA 91601	James M. Willson Los Angeles County Chapter NECA 675 S. Arroyo Parkway, Suite 300 Pasadena, CA 91105
Jerry McLinn IBEW Local Union 40 5643 Vineland Avenue North Hollywood, CA 91601	Mike E. Richards Los Angeles County Chapter NECA 675 S. Arroyo Parkway, Suite 300 Pasadena, CA 91105
Dave Grabowski IBEW Local Union 40 5643 Vineland Avenue North Hollywood, CA 91601	Henry Turner Los Angeles County Chapter NECA 675 S. Arroyo Parkway, Suite 300 Pasadena, CA 91105

Plan Administrator: Board of Trustees, IBEW Local 40-NECA Health Trust Fund. For day-to-day operations of the Plan, the Plan is administered by Coast Benefits, a third party administrator. The address and telephone for Coast Benefits is 3444 Camino del Rio North, Suite 106, San Diego, California 92108; telephone 800-886-7559.

Eligibility: Participants of IBEW Local 40 and employees of certain related Employers who have had hourly contributions paid to the Plan on their behalf.

Loss of Benefits: A loss of benefits for a Plan Participant, the Participant's Spouse and Dependents will occur when the Plan Participant's Account balance is zero.

Plan Costs: Paid through Participants' account balances.

Agent for Service of Legal Process: For disputes arising under the Plan, service of legal process may be made upon the Plan Trustees or the Plan's Legal Counsel, Melissa W. Cook, Esq., Melissa W. Cook & Associates, 3444 Camino Del Rio North, Suite 106, San Diego, CA 92108.

Plan Continuance: The Trustees expect and intend to continue the Supplemental Medical Plan indefinitely; however, the Sponsors and the Trustees reserve the right to amend or terminate the Plan.

YOUR RIGHTS UNDER ERISA

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

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 Employee Benefits Security Administration.

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

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 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 summary plan description and the documents governing the plan 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 when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your

COBRA continuation coverage ceases, 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 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 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 Ten Dollars ($110.00) a day until you receive the materials, unless the materials were not sent because of matters beyond the control of the Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suite in a state or 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 cot 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 underarms, 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.

INFORMATION REQUIRED BY THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

A federal law called the Health Insurance Portability and Accountability Act, referred to herein as HIPAA for short, requires this Plan to furnish you with certain information.

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

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

When you lose eligibility under this Plan, you will be furnished with what is *called Certificate of Group Health Plan Coverage*. This certificate provides you with evidence of your prior health coverage with this Plan. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the six months prior to your enrollment in the new plan.

If you become covered under another group health plan, check with the Administrative Office to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

HIPAA PRIVACY STATEMENT

HIPAA also gives you certain rights with respect to your health information, and requires that employee welfare plans, like the IBEW Local 40-NECA Health and Welfare Trust Fund, that provide health benefits, protect the privacy of your personal health information. A complete description of your rights under

HIPAA will be found in the Plan's Notice of Privacy Practices included in this section.

Since the Plan is required to keep your health information confidential, before the Plan can disclose any of your health information to the Board of Trustees, which acts as the sponsor of the Plan, the Trustees must also agree to keep your health information confidential. In addition, the Trustees must agree to handle your health information in a way that enables the Plan to follow the rules in HIPAA. The health information about you that the Board of Trustees receives from the Plan (except for any information that is received in connection with the death benefits) is referred to below as "protected health information." The Board of Trustees agrees to the following rules in connection with your protected health information:

- The Board of Trustees understands that the Plan will only disclose health information to the Board of Trustees for the Trustees' use in plan administration functions.

- Unless it has your written permission, the Board of Trustees will only use or disclose that protected health information for that plan administration, or as otherwise permitted by this Summary Plan Description, or as permitted or required by law.

- The Board of Trustees will not disclose your protected health information to any of its agents or subcontractors unless the agents and subcontractors agree to handle your protected health information and keep it confidential to the same extent as is required of the Board of Trustees in this Summary Plan Description.

- The Board of Trustees will not use or disclose your protected health information for any employment-related actions or decisions, or with respect to any other pension or other benefit plan sponsored by the Board of Trustees without your specific written permission.

- The Board of Trustees will allow you, through the Plan, to inspect and photocopy your protected health information, to the extent, and in the manner, required by HIPAA.

- The Board of Trustees will make available protected health information for amendment and incorporation of any such amendments to the extent, and in the manner required by HIPAA.

- The Board of Trustees will keep a written record of certain types of disclosures it may make of protected health information, so that it may make available the information required for the Plan to provide an accounting of certain types of disclosures of protected health information.

- The following categories of individuals under the control of the Board of Trustees are the only employees who may obtain protected health information in the course of performing the duties of their job with or for the Board of Trustees who obtained such health information:

- The Fund Administrator and other employees as designed by the Fund Administrator.

- These individuals will be permitted to have access to and use the protected health information only to perform the Plan administration functions that they provide for the Plan.

- The individuals listed above will be subject to disciplinary action and sanctions for any use or disclosure of protected health information that violates the rules set forth in this Summary Plan Description. If the Board of Trustees becomes aware of any such violations, the Board of Trustees will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to the participants whose privacy has been violated.

- The Board of Trustees will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan in order to allow the Secretary to determine the Plan's compliance with HIPAA.

The Board of Trustees will return to the Plan or destroy all your protected health information received from the Plan when there is no longer a need for the information. If it is not feasible for the Board of Trustees to return or destroy the protected health information, then the Trustees will limit their further use or disclosures of any of your protected health information that it cannot feasibly return or destroy.

OTHER INFORMATION YOU SHOULD KNOW AS REQUIRED BY HIPAA

1. HIPAA requires that Plan participants be notified of material reductions in health plan coverage within 60 days of the adoption. Contained in this Summary Plan Description is a section entitled "Plan Amendment Procedures" which explains the notice you will receive if there is a material reduction in benefits. This Plan will provide notice of such changes to Plan participants no less than 60 days after adoption.

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

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

FREQUENTLY ASKED QUESTIONS ABOUT HIPAA

Q. *If I change jobs am I guaranteed the same benefits that I have under my current plan?*

A. No. When a person transfers from one plan to another, the benefits the person receives will be those provided under the new plan. Coverage under the new plan can be different than the coverage under the former plan.

Q. *Will I be covered immediately under my new employer's plan?*

A. Not necessarily. Plans may set a waiting period before individuals become eligible for benefits. HMOs may have an "affiliation period" during which an individual does not receive benefits and is not charged premiums. Affiliation periods run concurrently with any waiting period under a plan and may not last for more than 2 months (3 months for late enrollees) and are only allowed for HMOs that do not impose pre-existing condition exclusion periods.

Q. *Does HIPAA require employers to offer health coverage or require plans to provide specific benefits?*
A. No. The provision of health coverage by an employer is voluntary. HIPAA does not require specific benefits nor does it prohibit a plan from restricting the amount or nature of benefits for similarly situated individuals.

Q. *What if my new employer does not provide health coverage?*
A. There is no requirement for any employer to offer health insurance coverage. If your new employer does not offer health insurance, you may be eligible to continue coverage under your previous employer's plan under COBRA continuation coverage.

Q. *What if I cannot afford the premiums for group health coverage?*
A. HIPAA does not limit premium rates, but it does prohibit plans and issuers from charging an individual more than similarly situated individuals in the same plan because of health status. Plans may offer premium discounts or rebates for participation in wellness programs. In addition, many states limit insurance premiums and HIPAA does not preempt state laws regulating the cost of insurance.

Q. *Does HIPAA extend COBRA continuation coverage?*
A. Generally no. However, HIPAA makes two changes to the length of the COBRA continuation coverage period.

Qualified beneficiaries who are determined to be disabled under the Social Security Act within the first 60 days of COBRA continuation coverage will be able to purchase an additional 11 months of coverage beyond the usual 18-month coverage period. This is a change from the previous law which required that a qualified beneficiary be determined to be disabled at the time of the qualifying event to receive 29 months of COBRA continuation coverage. This extension of coverage is also available to non-disabled family members who are entitled to COBRA continuation coverage.

COBRA rules are also modified and clarified to ensure that children who are born or adopted during the continuation coverage period are treated as "qualified beneficiaries."

PRIVACY STATEMENT

OUR RESPONSIBILITIES

The Plan is required to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice, notify you if we are unable to agree to a requested restriction, and accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. We reserve the right to change our practices and to make the new provision effective for all protected health information we maintain. Should our privacy practice change, we will mail a revised notice to the address you've supplied us with. We will not use or disclosure your health information without your written authorization, except as described in this notice. You may revoke your authorization to use or disclose health information except to the extent that action has already been taken.

EXAMPLES OF HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The IBEW Local 40 – NECA Health Fund has contracted with Putnam Investments to maintain Individual Health Reimbursement Accounts. Putnam contracts with WageWorks to adjudicate claims. HIPAA and the Medical Records Law require these organizations to protect the privacy of your personal health information.

The Health Fund does not maintain or have access to your personal health information that may be on file with WageWorks

If you have any questions pertaining to how WageWorks protects the privacy of your personal health information you should contact them directly.

BUSINESS ASSOCIATES

There are some services provided in our organization through contracts with business associates. When these services are contacted, we may disclose your health information to our business associate so that they can perform the job

we've asked them to. To protect your health information, however, we require the business associate to appropriately safeguard your information.

PUBLIC HEALTH

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

LAW ENFORCEMENT

We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

HOW WE OBTAIN PROTECTED HEALTH INFORMATION

Some of the protected health information that we collect comes directly from you. When submitting your application for insurance, you may give us information such as your name, address, and Social Security number. We collect information from outside sources, primarily health care providers and third party insurance companies.

WHAT WE DO WITH YOUR PROTECTED HEALTH INFORMATION

We use protected health information to provide health and welfare services to you. We may, without authorization but only as permitted or required by law, provide protected health information to persons or organization both inside and outside of IBEW Local 40-NECA Health and Welfare Trust Fund as stated below:

- in order to handle and/or investigate claims,
- fulfill a transaction you have requested,
- service your policy,
- detect and/or prevent fraud,
- comply with lawful requests from regulatory and law enforcement authorities,
- for distribution of health related benefits and services,
- for public health activities
- to Plan sponsor,
- when legally required,
- for organ and tissue donation
- to conduct health oversight activities,
- in connection with judicial and administrative proceedings

- for law enforcement purposes,
- to coroners, medical examiners and funeral directors,
- in the event of a serious health or safety event,
- for specified government function,
- for Worker's Compensation purposes,
- to individual(s) involved in your care or payment of your care,
- for HHS investigation and to business associates.

How Do We Protect Your Protected Health Information?

Protected health information within IBEW Local 40-NECA Health and Welfare Trust Fund is only available to those individual who need to see it to fulfill and service your needs. All employee and agents of IBEW Local 40-NECA Health and Welfare Trust Fund are instructed on the need to protect protected health information. In addition, we've established legal agreements with companies working IBEW Local 40-NECA Health and Welfare Trust Fund's behalf that require them to protect protected health information and to use that information only to provide the service we have asked them to perform. Should your relationship with the IBEW Local 40-NECA Health and Welfare Trust Fund end, your protected health information will remain protected in accordance with our privacy practices as outlined in this Privacy Notice.

YOUR HEALTH INFORMATION RIGHTS AND HOW YOU CAN FIND OUT WHAT INFORMATION WE HAVE ABOUT YOU

Your rights regarding the health information the Plan maintains about you are as follows:

RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

To inspect and copy health information maintained by the Plan, submit your request in writing to Plan. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

RIGHT TO AMEND

If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, send a detailed request in writing to the Plan. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was: accurate and complete, not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect or copy.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

You have the right to a request a list of certain disclosures the Plan has made of your PHI. This is often referred to as an "accounting of disclosures". You do not have a right to receive an accounting of any disclosures made:

- For Treatment, Payment or Health Care Operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;

- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a limited data set (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

To request an accounting of disclosures, submit your request in writing to the Plan. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request a restriction on the health information the Plan uses or disclosures about you for treatment, payment or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or a close friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

To request restrictions, make your request in writing to the Plan. You must advice us: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply.

NOTE: The Plan is not required to agree to your request.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location

To request confidential communications, make your request in writing to the Plan. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this notice. You may write to the Plan to request a written copy of this notice at any time.

MAKING REQUESTS

Please send any of the above requests listed above in writing to:

Board of Trustees
IBEW Local 40 NECA Health & Welfare Trust Fund
3444 Camino Del Rio North, Ste. 106
San Diego CA 92108

If you believe your privacy rights have been violated, you can file a complaint the Privacy Office (Board of Trustees) or you may also file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Please be aware we may periodically update or revise this Privacy Statement. If we change our Privacy Statement, a new notice will be sent to you. If you have any questions or would like more information, please don't hesitate to call IBEW Local 40-NECA Health and Welfare Administrative Office at (800) 886-7559.

EVENTS THAT TERMINATE BENEFITS

There are a number of different events that will result in the Termination of Benefits under this Plan for Participants, Spouses and Dependents.

TERMINATION FOR PARTICIPANTS

A Participant's benefit will terminate upon the earlier occurrence of any of the following events:

1. The reduction of a Participant's Account Balance to zero unless the balance is increased by subsequent Employer contributions.

2. Death of the Participant.

TERMINATION FOR SPOUSES OF PARTICIPANTS

The benefits of a Spouse of a Participant will terminate upon the occurrence of any of the following events:

1. The reduction of a Participant's Account Balance to zero unless the balance is increased by subsequent Employer contributions.

2. Death of a Participant, however if the Participant dies with an Account Balance, then claims for benefits under the Plan received from the Participant's Spouse and/or Dependents subsequent to the Participant's death will be paid from the Account Balance until the balance is reduced to zero.

3. When the Participant and Spouse become legally divorced.

TERMINATION FOR DEPENDENTS OF PARTICIPANTS

The benefits of a Dependent of a Participant shall terminate upon the occurrence of any of the following events:

1. The reduction of a Participant's Account Balance to zero unless the balance is increased by subsequent Employer contributions.

2. Death of a Participant, however if the Participant dies with an Account Balance, then claims for benefits under the Plan received from the Participant's Spouse and/or Dependents subsequent to the Participant's death will be paid from the Account Balance until the balance is reduced to zero.

3. When the Dependent no longer meets the Plan's definition of Dependent.

COBRA

Federal Law commonly known as COBRA, provides that you, your spouse and your dependents have the right to purchase a temporary extension of your group health benefits coverage at certain times when coverage under the Plan would end.

COBRA continuation coverage is a continuation of the coverage that would otherwise end because of a "qualifying event." A Participant's election of continued coverage shall apply to the Participant's Spouse and Dependent children of a Participant, unless specified otherwise. However, Spouses of Participants and Dependent children have an independent right to elect continuation coverage and may file a separate election form for that purpose. Parents may elect to continue coverage on behalf of their Dependent children.

The qualifying events for Participants, Spouses and Dependent children are as follows:

For a Participant–the reduction of a Participant's Account Balance to zero.

For a Spouse–because of any of the following reasons:

1. The earlier of the reduction of a Participant's Account Balance to zero or twenty-four (24) months after the death of a Participant;

2. Divorce from the Participant.

For a Dependent–because of any of the following reasons:

1. The earlier of the reduction of a Participant's Account Balance to zero or Twenty-four (24) months after the death of a Participant;

2. The Dependent ceases to meet the eligibility requirements for a Dependent as described elsewhere in this booklet.

When any of these events occur, complete details on how coverage may be continued will be provided to the affected persons. Any person who elects (COBRA continuation coverage must pay the amounts charged for such

coverage and that person will be advised of that amount at the time of receipt of the Notice of Termination.

You, or a Participant of your family, have the responsibility to notify the Plan office and provide appropriate certificates of any of the events described in the section "Changes to Report" above with respect to yourself, your Spouse or your Dependents. You must also notify the Plan of a determination by the Social Security Administration that a Participant, Spouse or Dependent have become disabled by submitting a copy of such determination to the Plan. Those notifications should occur as soon as possible and must occur within sixty (60) days (except that notification of the end of disability must be provided within thirty (30) days).

It is also important to notify the Plan of any changes in the addresses of all Participants, Spouses and Dependents.

The maximum period of a temporary continuation of benefits required by law is as follows:

- Eighteen (18) months in the case of ineligibility due to the Participants' reduction in hours or termination of employment except that such period is extended to twenty-nine (29) months for you or a Participant of your family if you or that Participant of your family becomes disabled during the first sixty (60) days of COBRA continuation coverage. Also, if the former Participant dies, enrolls in Medicare, or becomes divorced, or legally separated while receiving COBRA continuation coverage, the COBRA continuation coverage may be extended to a maximum of thirty-six (36) months. This extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child. In all of these cases, the Plan Administrator must be notified of the second qualifying event within sixty (60) days of the occurrence of the second qualifying event.

- Thirty-six (36) months for all other situations.

  The temporary continuation of benefits will also cover a child born to, or placed for adoption with, a Participant during the period of a temporary continuation of benefits.

The law provides that the continuation of coverage may terminate for any of the following reasons:

1. The Plan no longer provides coverage for any of its Participants;

2. The payments for the continuation of coverage are not made.

You will be notified of the termination of coverage and of the existence of your COBRA rights at the appropriate times. Each individual entitled to COBRA rights will be notified by First Class U. S. Mail. If a spouse or dependent resides with a Participant, one notice will be sent to the address, but each individual may make an independent election of COBRA extension.

REINSTATEMENT OF BENEFITS

USERRA -SERVICE IN THE ARMED FORCES

A Participant who enters active service in the Armed Forces on a full-time basis may elect either (a) or (b) with respect to his/her participation in this Plan:

a. To cease coverage under this Plan to freeze his/her Account balance under the Plan as of that date, or

b. To continue his/her coverage under the Plan under his/her Account Balance is used up.

If a Participant's health and welfare benefits are terminated because of his/her beginning active military service, the Participant will be reinstated to full coverage on the day the Participant again commences work with a signatory to the IBEW Local 40–NECA Inside Agreement or registers for dispatch under such Agreement with IBEW Local 40.

CLAIMS AND REVIEW PROCEDURE

WageWorks handles all aspects of the claims' adjudication process including appeals. If any part of your claim, in whole or in part, is denied you can appeal the denial directly to WageWorks. For example, a claim may be denied by WageWorks because the expense is not approved for payment under Internal Revenue Service rules.

Below is the information you need to appeal a claim denial to WageWorks:

TO APPEAL A DENIED CLAIM

If you feel your claim was denied in error, you have the right to file an appeal by writing a letter that explains why you believe the claim should be approved:

1. Your appeal must be submitted in writing and mailed to:

   WageWorks Claims Appeal Board
   P.O. Box 991
   Mequon, WI 53092-0991

2. Your appeal must be received within 180 days of the date you receive notice that your claim was denied.

3. If your claim was never received, your appeal, with proof of timely claims submission, must be received by the claim-it-by date for the plan.

4. You are welcome to submit additional information related to your claim along with your appeal, such as: written comments, documents, records, a letter from your health care provider indicating medical necessity of the denied product or service, any other information you feel will support your claim.

5. You can request copies of all documents and information related to your denied claim. These will be provided at no charge.

APPEAL REVIEW PROCESS

- Your appeal will be reviewed by a person who was not involved with the initial claim denial and who is not a subordinate of any person who was.
- The review will be a fresh look at your claim and appeal without deference to the initial denial and will take into account all information submitted with your claim and/or appeal.
- You will be notified of the decision regarding your appeal in writing by WageWorks within 30 days of receipt of your written appeal.

However, if you or your spouse is denied eligibility for a benefit by the Health Plan, you will be sent the reason for the denial and a copy of the procedure to be followed if you wish to appeal the denial from the Administrative Office. If you believe that the denial is not justified, you may submit a request for review of the denial. This request must be in writing and should be submitted within 60 days after the receipt of the notice of denial to the Administrative Office.

You may review any documents at the Administrative Office to help you in preparing your appeal, and you may submit any materials or comments you wish.

Your request for review will be considered by the Trustees and you will be notified of their decision.

If there is a substantial conflict between the information which you provide to the Trustees and the information which the Trustees relied upon in denying your claim for benefits, the Trustees may, at their decision, give you the right to appear personally before a committee of the Trustees to review your case.

The decision of the Trustees shall be final and binding upon all parties. In the event that you disagree with the decision of the Trustees, you may submit the matters to arbitration in accordance with the Rules for claims under employee Benefit Plans of the American Arbitration Association. The questions for the arbitrator shall be;

1) whether the Trustees were in error upon an issue of law;
2) whether the Trustees acted arbitrarily or capriciously in the exercise of their discretion; and

3) whether the Trustees' findings of fact were supported by substantial evidence.

You shall have the right to file an action in court after you have exhausted your administrative remedies including arbitration.

AMENDMENT OR TERMINATION OF PLAN

The Trustees reserve the right to change or discontinue any Plan benefits, in whole or in part, as they deem such action necessary. This action by the Trustees will be accomplished by a Plan Amendment that details in writing the changes made.

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