IBEW Local 40 - NECA
Health and Welfare Trust Fund

Summary Plan Description

For Eligible Active Participants
and their Eligible Dependents

Add wrap around box Kaiser, Delta & Health etc Plan document a copy of which can be obtained from the Administrative Office, Coast Benefits etc.

Caution: This document, together with the Evidence of Coverage booklet issued by Kaiser, Delta Dental is your Summary Plan Description. Please attach this Summary Plan Description to your Evidence of Coverage booklet. If the Evidence of Coverage booklet is not attached, then this Summary Plan Description is not complete and you should contact the Administrative Office or Kaiser or Delta Dental for another copy.

Effective July 1, 2008

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GENERAL INFORMATION

Administrative Office

IBEW Local 40 - NECA Health and Welfare Trust Fund
Coast Benefits
3444 Camino Del Rio North, Suite 106
San Diego, CA 92108

(800) 886-7559
Office Hours: Monday through Friday, 8:00 a.m. – 5:00 p.m., excluding holidays

Board Of Trustees

Labor Trustees:	**Management Trustees:**
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Dave Grabowski	Henry Turner

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Jonnette Tucker
Coast Benefits

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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 through 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, Delta Dental 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," on page 11 for further information.

LETTER OF INTRODUCTION - Welcome!

To: All Local 40 Active Employees and Their Eligible Dependents:

Welcome to the IBEW Local 40 - NECA Health and Welfare Trust Fund. This Trust Fund was established effective October 1, 1997. Under the Trust Fund, the Trustees are pleased to provide all eligible participants with comprehensive plans for both medical and dental coverage. The cost of these plans is paid entirely by employer contributions, as provided for under the applicable Collective Bargaining Agreements.

The Trustees have established an Administrative Office for your benefit. The employees at the Administrative Office are there to assist you in any way possible for the purpose of answering your questions and making certain that you receive all of the benefits to which you are entitled under the Trust Fund.

This booklet contains a general description of all benefits which eligible active electricians and their eligible dependents are entitled under the IBEW Local 40 - NECA Health and Welfare Trust Fund. The benefit plans described in this booklet are as follows:

- **Kaiser HMO Medical/Hospital Plan**
- **Delta Dental Plan**

The Health Plan was established for you as a result of a collective bargaining agreement between IBEW Local 40 and the Los Angeles Chapter of the National Electrical Contractors' Association. Your Employer has agreed under a provision of the collective bargaining agreement to make contributions to the Trust Fund that are used to pay for the costs of the benefit plans described above.

The power to administer the Trust Fund and adopt rules and regulations governing the payment of benefits is vested in the Board of Trustees. The payment of any benefit is subject to all terms and conditions of the Agreement and Declaration of Trust establishing the IBEW Local 40 - NECA Health and Welfare Trust Fund; Contracts issued to the Fund by the Kaiser Foundation Health Plan, Delta Dental, as well as any rules and regulations that the Trustees may adopt from time to time.

Benefits for the Plan are financed through Employer contributions that are specifically designated to provide health benefits for active Employees. There is no vested right to receive Plan benefits. The Trustees may change the Plan benefits at any time as a result of conditions or events requiring such action.

Any verbal or written representations made by any Employer, Employer Association, Union, or Health & Welfare Trust Fund Administrative Office employees or representatives will not be binding on the Board of Trustees.

The Board of Trustees' procedures for changing, enhancing, reducing, or eliminating benefits, are enumerated in the section entitled, "Plan Amendment Procedures" on page 28.

To assist you in obtaining Plan benefits, the Trustees have established an Administrative Office. However, any final decision concerning an individual's qualification for benefits under this Plan is made exclusively by the Board of Trustees. Again, any representations, either oral or written, made by employees of the Health & Welfare Trust Fund Administrative Office, by an Employer, Employer Association or Union employees or representatives, will not be binding upon the Board of Trustees.

This booklet was prepared for your assistance. Take time to read it and become familiar with its contents. If you have any questions concerning your benefits or need assistance, please call or write the Administrative Office. The address, phone number, and office hours are shown on page 2 under the heading "Assistance."

Sincerely,

The Board of Trustees
July 1, 2008

DEFINITIONS

General Plan Definitions

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

COBRA
The continuation of health care coverage when Plan eligibility coverage ends as provided for by the Consolidated Omnibus Budget Reconciliation Act (COBRA) and any changes or amendments to this law which may be enacted by law or regulation.

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.

Credited Hour
Credited hour means work hours reported under Covered Employment for which contributions are received. The term "Credited Hour" also includes any hour that is worked by an Employee with a Health Fund which is signatory to the International Brotherhood of Electrical Workers (IBEW) Reciprocal Agreement, provided contributions for these hours are remitted to this Fund. These hours will be credited based on the ratio between the hourly contribution rates of the remitting Fund and this Fund.

Dependent
This is as defined in this SPD booklet. Refer to page 11 under 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.

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

Family Member
An Employee or dependent of an Employee.

Fund or Health Fund
The IBEW Local 40 - NECA Health and Welfare Trust Fund.

HMO Hospital/Medical Plan
The Kaiser Foundation Health Plan. Under this Plan, you must use the doctors and hospitals associated with Kaiser, unless expressly otherwise provided.

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

Qualifying Event
A qualifying event for continuation coverage occurs when a qualified beneficiary loses coverage under this Plan for any of the reasons provided by COBRA. This entitles the qualified beneficiary to continuation coverage by self-payment.

Summary Plan Description and/or SPD
This document, distributed to the IBEW Local 40 - NECA Health and Welfare Trust Fund participants, which contains all or substantially all of the information the average participant would deem crucial to a knowledgeable understanding of his benefits and the circumstances that may disqualify a participant from securing those benefits under the Plan.

Trust Agreement
The Agreement and Declaration of Trust establishing the IBEW Local 40 - NECA Health and Welfare Trust Fund and any modification, amendment, extension, or renewal thereof.

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.

ELIGIBILITY & GENERAL PLAN PROVISIONS

Eligibility - When Coverage Begins

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

Important: Note sections entitled, "Bank Hours Termination" on pages 9 and 10 and "Cancellation Of Eligibility & Termination of Hours Bank Reserve" on page's 13 and 14.

WORKING LOCAL 40 ELECTRICIANS

You will be eligible for benefits under the IBEW Local 40 - NECA Health and Welfare Trust Fund the first day of the fourth calendar month next following the last month in which you had worked at least 120 hours.

For Example: 120 Hours Worked In	Gives Eligibility In
October	February
November	March
December	April
January	May
February	June
March	July
April	August
May	September
June	October
July	November
August	December
September	January

And in like manner thereafter unless these eligibility rules are amended by the Board of Trustees.

OWNERS/PARTNERS/CORPORATE OFFICERS - WORKING (MEMBER) LOCAL 40 ELECTRICIANS

There are separate eligibility rules applicable where an Owner, Partner, or Corporate Officer participates in this Plan as a working (member) Local 40 electrician.
To be eligible, as a working member, you must report a minimum of 120 hours

per month. The employer contribution rate will be a flat monthly amount, based on 120 hours per month times the highest Health and Welfare contribution rate, as provided in the Collective Bargaining Agreement.

Working Local 40 Owners, Partners, or Corporate Officers will only be eligible to participate in this Plan if they enroll within 60 days of signing a Collective Bargaining Agreement with Local 40.

Working Local 40 members as described above, who may otherwise be eligible to participate in this Plan, but either decline participation or do not enroll within the required 60 day time period, will be eligible to enroll in the Plan at anytime, upon receipt of the enrollment form in the Administrative Office.

ELIMINATION OF ELIGIBILITY WAITING PERIOD

A participant who transfers to this Fund, from another IBEW-sponsored health plan, will be eligible for the benefits of this Plan on the first of the month following completion of 120 reported hours in a month. Note: The effective date of coverage under this Plan, in all cases, will be delayed to the first of the month, following the month in which such participant loses eligibility in the fund from which he or she is transferring.

Continuation of Eligibility – Hours Bank Reserve

WORKING LOCAL 40 ELECTRICIANS

All hours worked in excess of 120 hours per month will be added to your reserve account. The maximum you can accumulate in your reserve account is 600 hours. Your eligibility will continue as long as your reserve account contains at least 120 hours.

Working Members

For working members who are owners, partners, or corporate officers of an Employer that is in non-compliance with the contribution provisions of their agreements, bank hours will be terminated forty-five (45) days after the working member receives notice from the Health Fund of the non-compliance if it has not been corrected in that forty-five day period.

Non-Bargaining Participation

The Board of Trustees of the IBEW Local 40-NECA Health & Welfare Trust

Fund has opened up participation in the Trust Fund to the non-bargaining staff of contractors who are signatory to the Local 40 inside agreement. Participation in the Health Trust Fund by non-bargaining staff is optional with the employer. If a contractor chooses to cover its non-bargaining staff, all staff must be covered.

To participate in the Health & Welfare Trust Fund, a contractor will be required to pay monthly contributions for each non-bargaining employee based on the number of hours worked or 120 hours, whichever is greater. In addition, for contractors that have existing health insurance coverage for their members, you may cancel that coverage and receive immediate eligibility under the Plan.

Kaiser Permanente provides medical benefits and dental coverage is provided through Delta Dental.

Newly signatory contractors are given up to sixty (60) days to opt into the Health Plan. If a contractor declines initial coverage for its non-bargaining staff, participation will not be available until 12 months have lapsed from the date of the declination.

Contact the Administrative Office for additional information.

Participants Working for Non-Signatory Employers

The Hours Bank Reserve shall immediately terminate for Employees employed by an Employer, who ceases contributions to this Plan pursuant to the termination of such Employer's collective bargaining agreement.

The Hours Bank Reserve shall immediately terminate for Employees employed in the electrical construction contracting industry by an Employer who is not a contributing Employer to this Plan or any other IBEW-sponsored health plan.

Eligible Dependents

The legal wife, or husband (California and this Health Plan do not recognize a common law spouse), of the Employee and the Employee's unmarried children (including a step child or a legally adopted child) under 19 years of age. As required by law, an eligible dependent will include a child under age 18, when placed with an Employee for adoption. When a child reaches his 19th birthday and continues to be unmarried and dependent upon the Employee, he will continue to be covered for hospital/medical and dental benefits through age 24 if he/she is attending an accredited school on a full-time basis (8 or more units). An eligible dependent includes any stepchild of the Employee who depends upon the Employee for support and lives with the Employee in a regular parent-child relationship and is claimed as a dependent on the Employee's income tax return. Refer to Kaiser's definition of dependent.

Student continuation coverage must be supported by a form from the eligible Employee to the Administrative Office.

Upon dissolution, divorce, legal separation, or annulment, a spouse ceases to be an eligible dependent on the date of the final decree. In order to avoid payment of claims and premiums for ineligible dependents, for which you will be deemed responsible, you should notify the Administrative Office of a dissolution, divorce, or annulment as soon as it occurs.

I.O. Health Reciprocal Agreement

It is recognized that some Employees fail to qualify for Health coverage because they travel out of the geographic area covered by the Plan. In accordance with national I.O. Guidelines, contributions received from another Health Fund that participates in the I.O. Health Reciprocity Agreement will be credited to the Employee as hours worked. To be eligible for I.O. Health Reciprocity, you must have been a participant (eligible for benefits) in this Fund within the past six years. However, if the hourly contribution rate of the participating local is less than the rate of the home local (Local 40), the hours credited to the Employee will be pro-rated.

The employee will have the option to self-pay the difference between the Plan's required contribution and the contribution received via reciprocity on a month-to-month basis to obtain coverage, or utilize sufficient hours from the Hours Bank to make up the difference. If no affirmative election is made by the employee the employee's Hours Bank will be initially utilized for this purpose until it is exhausted.

For example, if an Employee works 150 hours in a reciprocal area where the hourly Health contribution rate is $3.00, and the Employee designates Local 40 as the home local, with a current hourly Health contribution rate of $4.44, the hours would be pro-rated as follows:

Participating local rate $4.00 / Home local rate $4.44 = 90.1%
150 hours x 90.1% = 135.2 credited Health hours

Termination or Reduction of Coverage

A participant's coverage will terminate on the earliest date of any of the following:

A) You enter Military Service
B) On the date you lose eligibility (including loss of eligibility as described above under "Bank Hours Termination")
C) Termination of any coverage. For example, a Plan is terminated.

The benefits for a dependent will terminate when the Employee's eligibility terminates or when the dependent no longer meets the definition of dependent as provided below under the section entitled, "Eligible Dependents" on page(s) 10 and 11.

Exception: If the termination is due to the death of the participating Employee, the benefits for his eligible dependents shall continue until such deceased Employee's bank hours, if any, have been exhausted.

Military Service

An Employee who lost eligibility because of his entrance into the United States Armed Forces will be covered for benefits immediately upon returning to Covered Employment provided the Employee returned to work within ninety (90) days immediately following the date of discharge from military service. The Employee should immediately notify the Administrative Office of any period of military service and discharge.

An Employee who is on military leave of less than 31 days shall be entitled to coverage under this Plan during the period of military leave.

An Employee who is on military leave of more than 31 days has the option of continuing coverage under this Plan for a period of up to 24 months from the date military leave begins. To obtain continued coverage for you and/or your eligible dependents under this Plan for military leave in excess of 31 days, you must pay the COBRA rate established for such continuation coverage, as discussed on page 15.

You must notify the Administrative Office in writing prior to commencing military leave. Under no circumstances, however, will the Plan be responsible for treatment of any service-related injuries or illnesses.

Qualified Medical Child Support Order (QMCSO)

As required by law, the Plan recognizes Qualified Medical Child Support Orders, called QMCSO for short. A Qualified Medical Child Support Order is issued by

the Court in divorce cases.

A QMCSO recognizes a child's right to receive Plan benefits, as a beneficiary of an eligible Plan participant. The child, to be covered by the benefits of this Plan, must meet the age requirement and definition of eligible dependent as defined previously under the section entitled, "Eligible Dependents."

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

1) You must provide the Administrative Office a copy of your Court ordered QMCSO.
2) Within thirty (30) days after receipt of the QMCSO, the Administrative Office will notify you and the eligible dependent (through his or her custodial parent, guardian or representative), in writing, if the QMCSO is recognizable by the Plan.
3) If the Plan determines that the Court order does not constitute a QMCSO, or additional information is required, you and the eligible dependent (through his or her custodial parent, guardian or representative) will be notified in writing by the Plan.
    a) If the QMCSO is denied, the notice shall describe the reasons for this decision. You have a right to appeal a denial, and the Plan's appeals procedures will be included along with the notice of denial.
    b) If additional information is required, you will be notified as to what is needed, and will have sixty (60) days to respond. If you do not respond within sixty (60) days, the request for the QMCSO will be deemed cancelled.

Cancellation of Eligibility & Termination of Hours Bank Reserve

Trust Agreement Non-Compliance & Contribution Reporting Requirements

A participant who has accrued Bank Hours under this Plan will lose all of his or her Bank Hours and will not be entitled to further coverage under this Plan for his or her previously accrued Bank Hours in the event that:

1) The participant continues to be employed by an Employer who ceases contributions to this Plan pursuant to the termination of such Employer's collective bargaining agreement; or
2) The participant becomes employed in the electrical construction contracting industry by an Employer who is not a contributing Employer to this Plan or any other IBEW-sponsored health plan.

The eligibility of an Employee, in the capacity of Owner, Partner, or Corporate Officer, will be cancelled if such Employee is in non-compliance with the Trust Agreement contribution reporting requirements.

The Administrative Office will provide a notice to the participant that their Employer is in non-compliance with the contribution provisions of the Trust Agreement.

Effective the first of the month, following forty-five (45) days after receipt of such notice, the eligibility of the working Employee, as an Owner, Partner, or Corporate Officer, will terminate, and all eligibility reserve bank hours will be cancelled.

Financing of the Plan

For working Employees, your benefits are paid from contributions made by Employers pursuant to a collective bargaining agreement. Under certain circumstances, your health care coverage may continue by making a self-payment (COBRA). For further details, see the next section.

Six Federal Laws You Should Know About

COBRA

Introduction

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA), requires that this plan offer you and your eligible dependents the opportunity for a temporary extension of health care coverage at group rates in certain instances when coverage under the plan would otherwise end (called "qualifying event"). Continued coverage under COBRA applies to the health care benefits described in this booklet.

The benefits under COBRA are the same as those covering people who are not on continuation coverage. You should also keep in mind that each individual entitled to coverage as the result of a qualifying event has a right to make his or her own election of coverage. For example, your spouse or other covered dependent may elect COBRA coverage even if you do not.

IMPORTANT, the continuation of health care coverage as explained below requires that you must make a payment each month to the Administrative Office within the time periods explained below. Don't forget that the Administrative Office does bill for COBRA coverage and it is your responsibility to make COBRA payments on time. If you don't make your payment on time, your coverage will end.

Under the law, the election of COBRA rights must be made in writing within 60 days of the later: (1) the date the COBRA notice is sent to you or (2) the date your regular Plan coverage terminates. You must make your first payment to the Trust Fund for COBRA continuation coverage within forty-five (45) days after you first elect COBRA coverage.

When you make your first COBRA payment, you must pay for all months that are due. Payments of subsequent months are due on the first of each month, and your COBRA coverage will terminate for non-payment if payment is not received in the Administrative Office within 30 days. For example, a payment for the coverage month of January is due January 1st, and if payment is not received in the Administrative Office by January 30th, your COBRA continuation coverage will end effective January 1. Thus, there is no coverage for January.

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

Frequently Asked Questions and Answers

The following questions and answers should help you understand your COBRA rights.

Q. *Provide a common example of a situation which might occur, causing me to lose my eligibility for benefits under the Trust.*

A. Your eligibility terminates because you did not work the required hours to maintain eligibility, and there are not enough hours in your eligibility reserve account to maintain eligibility. This event

would qualify you to continue coverage under COBRA by making a self-payment.

Q. *How long are my COBRA benefits available?*
A. A qualified participant is entitled to 18 months of continued coverage if the qualifying event is termination of employment (other than gross misconduct) or a reduction of employment hours. This may be extended 11 months if you are considered disabled under the Social Security Act. Any other qualifying event increases the available coverage term for qualified beneficiaries to 36 months (maximum). Refer to the "Qualifying Events" section below. Also, Kaiser provides COBRA coverage under CAL-COBRA, which extends coverage up to a maximum of 36 months if COBRA premiums are continually paid.

Q. *I am an employee and make COBRA payments. Are my dependents covered for Plan benefits?*
A. Yes, provided you pay the Kaiser singular COBRA rate that includes COBRA coverage for all eligible dependents of the Employee. The definition of eligible dependents defined by the Plan is contained in the section entitled "Eligibility and General Plan Provisions" subtitle "Eligible Dependents". Also, children born or adopted during the period of continuation coverage are considered dependents, the same as those of active eligible employees. (However, this applies only if the covered employee elects COBRA coverage during the election period and enrolls the new child upon birth or adoption.)

Q. *How is the COBRA self-payment calculated?*
A. Under the COBRA law, the Trustees are permitted to base the self-payment on a formula, which is the Plan cost plus 2% for administration. For example, if you are covered under Kaiser your monthly COBRA payment for continuation coverage is based on the applicable HMO premium cost, plus 2% for administration. Note, for a disabled qualified participant, the premium for months 19 through 29 may be no more than 150% of the applicable non-COBRA premium.

Q. *How often do I make a COBRA self- payment?*
A. Payments must be paid monthly.

Q. *How much will the COBRA self-payment cost?*
A. The self-payment for continuation coverage will be the full amount allowed under COBRA. The Administrative Office can provide you with the cost applicable to the medical plan you have selected.

Q. *What is "basic" coverage?*
A. Basic coverage is hospital/medical (Kaiser) "Core-Only" coverage.

Q. *Who can pay the cost of my COBRA continuation coverage?*
A. Of course, you can pay the monthly premium. However, it is also permitted for a third party to pay the premium, such as a family member, hospital, or your employer.

Q. *What is the whole plan of benefits?*
A. Medical/hospital, dental, vision, and prescription drug benefits, which is called "Core-Plus or Core-Full."

At a Glance
Qualifying Events That Entitle You To COBRA

The following table may be of assistance:

If you Lose Coverage Because	These People Would Be Eligible	COBRA Coverage Maximum

of This Reason (a "qualifying event")	for COBRA:	Length (measured from the date coverage is lost)
Your employment terminates*	You and your covered spouse and children	18 months**
Your working hours are reduced	You and Your covered spouse and children	18 months**
You die	Your covered spouse and children	36 months
You divorce or legally separate	Your covered spouse and children	36 months
Your dependent child(ren) no longer qualifies as an eligible dependent	Your covered children	36 months
You become entitled to Medicare	Your covered spouse and children	36 months
* For any reason other than gross misconduct (and including military leave and approved leaves granted according to the Family and Medical Leave Act).		
** Continued coverage for up to 29 months from the date of the initial event may be available to those who, during the first 60 days of continuation coverage, become totally disabled within the meaning of Title II, or Title VXI of the Social Security Act. This additional 11 months is available to employees and enrolled dependent if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of coverage will increase to 150% of the full cost of coverage. Additionally, coverage can be extended for eligible dependents to a maximum of 36 months in the event of death or Medicare entitlement of the employee or divorce or legal separation. If you are enrolled in an HMO, you can elect Cal-COBRA from your HMO for an additional 18 months. In no event will Federal COBRA and Cal-COBRA exceed 36 months total.		

Employees

If you have established eligibility under the Plan, you have the right to choose this continuation coverage if you lose health coverage under this Plan for any of the following reasons:

1. You lose your IBEW Local 40-NECA Health & Welfare Trust Fund coverage because of a reduction in your number of hours of covered employment;
2. Your employer has filed for bankruptcy reorganization under Chapter 11 of the United States Bankruptcy Code; or
3. Your employment is voluntarily or involuntarily terminated (for reasons other than gross misconduct on your part) with a contributing Employer as defined in the "Definitions" section of this booklet
4. For employees on a Family Medical Leave Act (FMLA) leave of absence, the qualifying event occurs when the employee fails to return to work at the end of the FMLA leave, or if earlier, when the employee gives notice to the employer that they will not be returning to work. The period of COBRA coverage begins on the date that coverage is lost due to the employee's failure to return to work from the leave granted under FMLA.

Spouses

If you are the legal spouse of an Employee covered for health care benefits under this Plan, you have the right to choose continuation coverage for yourself if you lose health coverage under this Plan for any of the following reasons:

18-month maximum continuation coverage period:

1. Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
2 If you are enrolled in an HMO, you can elect Cal-COBRA from your HMO for an additional 18 months. In no event will Federal COBRA and Cal-COBRA exceed 36 months total;

36-month maximum continuation coverage period:

3. Covered Employee's death;
4. Divorce or legal separation from your spouse;
5. Your spouse becomes eligible for Medicare; or
6. Your spouse's Employer files for Chapter 11 reorganization.
7. If you are enrolled in Kaiser, you can elect Cal-COBRA from your HMO for an additional 18 months. In no event will Federal COBRA and Cal-COBRA exceed 36 months total.

Children

If you are a dependent child, (as defined under the Section entitled, "Eligible Dependents") of an Employee covered for health care benefits under this Plan, you have the right to choose continuation coverage for yourself if you lose health coverage for any of the following reasons:

18-month maximum continuation coverage period:

1. Termination of your parent's employment (for reasons other than gross misconduct) or reduction in your parent's hours of employment;

36-month maximum continuation coverage period:

2. Parent's divorce or legal separation;
3. Covered parent's death;
4. The parent covered under the IBEW Local 40-NECA Health and Welfare Trust Fund Southern California Health & Welfare Plan becomes eligible for Medicare;
5. The dependent ceases to be a "dependent child" under the Plan rules; or
6. The parent's Employer files for Chapter 11 reorganization.

Notification

An employer must notify the Administrative Office of your death, termination of employment, reduction in hours of employment or Medicare entitlement no later than **60 days after your loss of coverage due to one of these events**. However, you or your family should also notify the Administrative Office if such an event occurs, in order to avoid confusion as to your status. You or your eligible dependents are responsible for informing the Administrative Office of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the date of the event. If the Administrative Office is not notified within the 60-day time limit, your dependents will lose the right to elect COBRA.

A qualifying event means the reason you are losing eligibility under one of the situations described above, such as termination of an employee's employment. Another example of a qualifying event for a legal spouse would be divorce. For a dependent, he or she may turn age 19 and no longer be an eligible dependent under Plan rules. If you do not notify the Administrative Office by the end of that period, your dependents will not be entitled to continuation coverage.

When the Administrative Office is notified that one of these events has happened, the Administrative Office will within 14 days, in turn, notify you that you have the right to choose continuation coverage. This notice will also explain the monthly payment you must pay to continue your health coverage. Under the

law, the election of COBRA rights must be made in writing within 60 days of the later: (1) the date the COBRA notice is sent to you or (2) the date your regular Plan coverage terminates.

Children born or adopted during the period of continuation coverage are considered dependents, the same as those of active eligible Employees. Remember, you must enroll your newborn or adopted child by notifying the Administrative Office within 30 days of acquiring the new dependent. Contact the Administrative Office for the necessary forms to enroll this new dependent.

If you do not choose continuation coverage by making a self-payment, coverage under this Plan will end. You will not be able to elect COBRA Continuation Coverage at a later date.

Benefits & Length of Coverage

If you choose "Basic" continuation coverage, it will be the same hospital/medical coverage (Kaiser) which was previously provided to you under the Plan. A qualified beneficiary is entitled to 18 months of continued coverage if the qualifying event is termination of employment or a reduction of employment hours. This may be extended 11 months, for a total of 29 months if at the time of the qualifying event, an Employee or his dependent(s) are determined to be if you are disabled under the Social Security Administration. To be eligible for the special 11-month extension, the disabled individual must notify the Administrative Office within 60 days following the later of the date on which the individual receives the initial COBRA notice following a qualifying event or the date Social Security determines that the individual is disabled before the end of the initial 18-month period of COBRA continuation coverage. Any other qualifying event increases the coverage term for qualified beneficiaries to 36 months (maximum).

If another qualifying event occurs during the 18-month period of continued coverage (29 months in case of a disability extension), the spouse or dependent children may be entitled to an additional 18-month extension for up to 36 months (maximum). In no case may the total amount of continued coverage be more than 36 months.

If you are enrolled in an HMO, you can elect Cal-COBRA from your HMO for an additional 18 months. In no event will Federal COBRA and Cal-COBRA exceed 36 months total

Cancellation of Your COBRA Coverage

Your COBRA coverage may be terminated prior to the end of the 18,29 or 36 months for any of the following reasons:

1. The signatory Employers to the Plan no longer provide group health coverage benefits to any of its Employees;
2. Payment for COBRA continuation coverage is not paid in a timely manner when due;
3. You become covered for benefits under another group health plan provided such plan does not contain any exclusions or limitations with respect to any pre-existing conditions;
4. Coverage has continued for the maximum 18, 29 or 36 month period, measured from the date coverage is lost;
5. The Board of Trustees terminates a particular coverage for all participants of the Plan. If coverage is changed or eliminated, persons on COBRA only have the right to choose among the options offered to similarly situated non-COBRA beneficiaries;
   For example, if the Trustees were to terminate an HMO contract under which you were covered under COBRA, and another HMO was offered to all other Plan participants in the canceled HMO, you would be allowed to enroll in the replacement HMO.
6. You request that your COBRA coverage be canceled. If you request termination, the coverage will generally end on the first day of the month following completion of a 30-day period beginning on the

date the Administrative Office received your written notice. For example, if they received your letter on May 15, the 30-day period would end on June 15, and the coverage would end July 1;
7. You become entitled to Medicare benefits **after** COBRA coverage has been elected;
8. You are no longer disabled. If a qualified beneficiary is determined to no longer be disabled under the Social Security Act before the end of the 29-month maximum coverage period, COBRA coverage may be terminated in the month that is more than 30 days after such determination is made
9. This Plan is terminated.

You do not have to show that you are in good health to choose continuation coverage. COBRA continuation coverage does **not** apply to life insurance benefits.

Cost of Continuation Coverage

The cost of continuation coverage is based on the medical plan (Kaiser) in which you are enrolled as of the date of the qualifying event. You also have the opportunity to choose between "Basic Coverage" (also referred to as "core-only" coverage) or the whole plan of benefits ("core-plus") with the exception of life insurance.

The premium (what you pay) for disabled qualified participants may be 150% of the benefit Plan cost during the 19th through 29th months of their coverage. You also have the opportunity to choose between "Basic Coverage" (core-only) or the whole plan of benefits ("core-plus").

Basic coverage provides hospital/medical benefits (under the plan selected). This is the least expensive continuation coverage. Alternately, you can choose "core-plus" which adds benefits for prescription drug, dental and vision care. The benefits provided on all continuation coverage are as explained in this booklet.

You should write or phone the Administrative Office to receive a copy of the cost sheet which provides the continuation rates that apply to you. The phone number and address are shown on the first page of this booklet.

Paying for COBRA Coverage

You have to pay the full cost of continued coverage under COBRA, plus a 2% administrative fee. (If you are eligible for 29 months of continued coverage due to disability, the law permits the Administrative Office to charge 150% of the full cost of the plan during the 19th to 29th months of coverage). The following rules apply in making your COBRA payments:

- It is easiest to make your first payment when you file your COBRA election form, that is, within 60 days from the date your Plan coverage would otherwise end. In no event may your payment be made later than 45 days from the date you mail your signed election form to the Administrative Office. Your first check should cover the period from the date your group coverage ended (and COBRA coverage began) through the current month.
- All subsequent payments after the first payment will be due on the first day of each month for that month's coverage. For example, a payment for the coverage month of January is due January 1st, and if payment is not received in the Administrative Office by January 30, your COBRA continuation coverage will end. Thus there is no coverage for January. Keep in mind that the Administrative Office does send monthly bills for COBRA coverage but it is your responsibility to see that your payment is at the Administrative Office by the due date.
- There is a 30-day grace period for all subsequent payments (for example, the end of the grace period for payment for coverage in the month of January is January 30). However, if you have a claim during a month for which you have not paid your premium. The claim will not be paid until the Administrative Office receives your payment for the month.

COBRA premiums are generally reviewed at least once a year and are subject to change.

You will be notified by the Administrative Office if the amount of your monthly payment changes. In addition, if the benefits change for active employees, your coverage will change as well.

Dependent/Spouse Change or Address Change

Contact the Administrative Office if you change your marital status or if you or your spouse change addresses.

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.

IMPORTANT: The medical plan (Kaiser) offered through the IBEW Local 40-NECA Health and Welfare Trust Fund **does not** contain any pre-existing condition exclusions. When you become eligible for benefits under this Plan, as explained in the section entitled "Eligibility - When Coverage Begins," all covered benefits become effective on the date you become eligible for benefits under this Plan.

However, Kaiser does have benefit exclusions and limitations for designated illnesses and conditions. For example, Kaiser contains an exclusion for experimental surgery. A summary of the exclusions for Kaiser is contained in this Summary Plan Description. Further information can be obtained by contacting the Administrative Office, or the HMO benefit provider. Also, refer to the Evidence of Coverage booklet provided to you by the HMO in which you are enrolled.

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. Certain benefit plans under the IBEW Local 40- NECA Health and Welfare Trust Fund have benefits guaranteed under contract between the Board of Trustees and the benefit provider. The following providers have guaranteed benefits by contract with the Board of Trustees.

   Medical Plans – Kaiser Permanente (HMO)
   Dental Plan – Delta Dental

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

3. 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 Kaiser Permanente to provide your medical benefits and has contracted with Delta Dental to provide your dental benefits. 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 either Kaiser Permanente or Delta Dental.

If you have any questions pertaining to how either Kaiser or Delta Dental protect 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.

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- **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 Alimited 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.

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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.**

The Newborns' and Mothers' Health Protection Act (Newborns' Act)

This law includes important protections for mothers and their children with regard to the length of the hospital stay following childbirth.

Health plans are required to provide coverage for a minimum of a 48-hour stay for the mother and newborn following a vaginal delivery, and at least 96-hour maternity stay following a cesarean section. Under this new law, a mother and newborn can leave prior to the minimum stay, provided there is a mutual agreement between the mother and doctor. Kaiser provides this maternity benefit.

If you have any questions, contact Kaiser directly, or call the Administrative Office for assistance.

Frequently Asked Questions About the Newborns' Act

Q. *I am a pregnant woman. How does the Newborns' Act affect my health care benefits?*
A. The Newborns' Act affects the amount of time you and your newborn child are covered for a hospital stay following childbirth. Group health plans, insurance companies, and health maintenance organizations (HMOs) that are subject to the Newborns' Act may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider may decide, after consulting with you, to discharge you or your newborn child earlier. In any case, the attending provider cannot receive incentives or disincentives to discharge you or your child earlier than 48 hours (or 96 hours).

Q. *Who is the attending provider?*
A. An attending provider is an individual licensed under state law who is directly responsible for providing maternity or pediatric care to a mother or newborn child. Therefore, a plan, hospital, insurance company, or HMO would not be an attending provider. However, a nurse midwife or a physician assistant may be an attending provider if licensed in the state to provide maternity or pediatric care in connection with childbirth.

Q. *Under the Newborns' Act, when does the 48-hour (or 96-hour) period start?*
A. If you deliver in the hospital, the 48-hour period (or 96-hour period) starts at the time of delivery. So, for example, if a woman goes into labor and is admitted to the hospital at 10 p.m. on June 11,

but gives birth by vaginal delivery at 6 a.m. on June 12, the 48-hour period begins at 6 a.m. on June 12.

Q. *Under the Newborns' Act, may a group health plan, insurance company, or HMO require me to get permission (sometimes called prior authorization or precertification based upon medical necessity) for a 48-hour or 96-hour hospital stay?*

A. A plan, insurance company, or HMO cannot deny you or your newborn child coverage for a 48-hour stay (or 96-hour stay) because the plan claims that you, or your attending provider, have failed to show that the 48-hour stay (or 96-hour stay) is medically necessary.

However, plans, insurance companies, and HMOs generally can require you to notify the plan of the pregnancy in advance of an admission if you wish to use certain providers or facilities, or to reduce your out-of-pocket costs.

Women's Health & Cancer Rights Act (WHCRA)

A federal law requires group health plans (HMOs and other insurers) providing coverage for mastectomies to also cover reconstructive surgery after a mastectomy. The purpose of this section is to remind you and your covered spouse of the following:

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

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications in all stages of the mastectomy, including lymphedemas,

in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions that are consistent with those established for other benefits under the plan or coverage.

If you have any questions, contact Kaiser directly, or call the Administrative Office for assistance.

Frequently Asked Questions About the WHCRA

Q. *I've been diagnosed with breast cancer and plan to have a mastectomy. How will WHCRA affect my benefits?*

A. Under WHCRA, group health plans, insurance companies, and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery, and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Q. *Will WHCRA require all group health plans, insurance companies, and HMOs to provide reconstructive surgery benefits?*

A. All group health plans, and their insurance companies or HMOs, that provide coverage for medical and surgical benefits with respect to a mastectomy are subject to the requirements of WHCRA.

Q. *Under WHCRA, may group health plans, insurance companies, or HMOs impose deductibles or coinsurance requirements for reconstructive surgery in connection with a mastectomy?*

A. Yes, but only if the deductibles and coinsurance are consistent with those established for other benefits under the plan or coverage.

The Mental Health Parity Act (MHPA)

As required by federal law, the IBEW Local 40-NECA Health and Welfare Fund is required to furnish you with information on the Mental Health Parity Act, or MHPA for short. Generally speaking, the purpose of the MHPA is to require health plans that offer mental health benefits, to provide parity in the application of lifetime dollar limits on mental health benefits in the same manner as provided for medical/surgical benefits.

There are however many other provisions of the law which also allow health plans flexibility. For example, there is no requirement that health plans even provide mental health benefits. Also, this law does not apply to benefits for substance abuse or chemical dependency.

Another important aspect of this law is that a health plan can choose to remove mental health benefits from their core medical plan, and offer a separate mental health plan (called a "carve out") with a totally separate set of benefits. For example, the plan can require that all hospital stays be approved, and further that the number of days of coverage be limited. There can also be limits on the number of outpatient visits for psychotherapy allowed under the plan.

Below is a simplified explanation of the benefits you are entitled to for mental health benefits under the IBEW Local 40-NECA Health & Welfare Trust Fund.

Kaiser Participants

HMO members will receive benefit coverage for the diagnosis and medically necessary treatment of serious mental illness (SMI) and serious emotional disturbances (SED) of a child. SMI includes the following conditions:

- Anorexia Nervosa
- Bipolar Disorder
- Bulimia Nervosa
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Pervasive Developmental Disorder, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism.
- Schizoaffective Disorder
- Schizophrenia

The Evidence of Disclosure booklet you received from your HMO will have a complete explanation of this benefit. If you have additional questions, you should contact Kaiser at the toll-free number provided. Of course, if you need further assistance or have questions you can always contact the IBEW Local 40-NECA Health & Welfare Trust Fund Administrative Office.

For Military Service (USERRA)

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

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

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

2. Military Leaves of Absence for Periods More Than 30 Days

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

   b. The maximum period of continuation coverage for health care under USERRA is the lesser of: (1) 24 months (beginning from the date the Employee leaves work due to military leave) or (2) the Day after the date the Employee fails to timely apply for or return to a position of employment with an Employer participating in the Trust or (3) when the Employee fails to timely pay for USERRA leave.

3. Upon release from active service, the Employee's coverage will be reinstated on the Day he returns to work as if he had not taken leave or as of the date of registration for employment through the Union, provided he is eligible for re-employment under the terms of USERRA and provided he returns to work within:

   a. Ninety (90) Days from the date of discharge if the period of service was thirty-one (31) Days or more;

   b. At the beginning of the first full regularly scheduled working period on the first calendar Day following discharge (plus travel time and an additional eight hours) if the period of service was less than thirty-one (31) Days;

   c. If the Employee is Hospitalized or convalescing from an Injury caused by active duty, these time limits are extended for up to two (2) years.

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

4. If the Employee does not elect to continue coverage during his military leave, upon his return to work his benefit coverage will be reinstated at the same benefit level afforded to active eligible Employees if he/she is eligible for re-employment under the criteria established under USERRA.

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

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

PLAN AMENDMENT PROCEDURES

Changing, Enhancing, Reducing, or Eliminating Benefits

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

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

Notification of Plan Changes to Participants

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

Such action by the Trustees will be accomplished by a Plan Amendment 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.

THE KAISER HMO PLAN

Basic Information

As a participant in this Plan, you are entitled to medical and prescription drug benefits under Kaiser provided you meet the eligibility requirements of the Plan.

Kaiser owns its own medical clinics and hospitals, and employs its own doctors. Kaiser may also contract with designated hospitals and Medical Groups. Under the Kaiser Plan, you can choose your own physician, and are encouraged to do so. You must live or work within the list of Kaiser zip codes to be eligible to enroll in the Kaiser Plan. You can use any Kaiser facility at any time and are not restricted to a particular Medical Group. There are specialist doctors within Kaiser and covered benefits are generally provided to you at no cost or for a fixed copayment.

Once enrolled, you can use any Kaiser facility. However, it is suggested that you choose a Kaiser facility closest to your home, or most convenient for you to receive most of your care.

Kaiser Plan benefits apply only when your care is provided, prescribed, or directed by a Kaiser physician except where specifically stated in emergency situations as described in the Kaiser descriptive literature. It is important to note that in order to receive covered benefits, you must use a Kaiser Plan facility to provide care for you and your dependent(s). Referrals to certain specialists may require a referral by your Kaiser doctor.

Complete benefits and information about the Kaiser Plan are described in their descriptive literature or call the Customer Service Call Center at (800) 464-4000. The services provided are summarized below.

Kaiser will provide you with complete descriptive literature after you enroll in the Kaiser HMO Plan, including an identification card. The medical facilities you must use are listed in the HMO brochure. Importantly, you must use the doctors and hospitals associated with Kaiser's HMO Plan.

In the following sections, we have provided you with information about the Kaiser HMO Plan available through the Trust. However, this information is only a summary, included herein for easy reference. For complete information about the Kaiser HMO Plan, you should contact the Administrative Office or Kaiser and request that they send you complete descriptive literature about the Plan.

In Case of an Emergency

An emergency is a sudden, unforeseen illness or injury that requires immediate medical attention.

Emergency care and urgent care are available from Kaiser Permanente 24 hours a day, 7 days a week. All necessary care, emergency or otherwise, should be obtained at a Plan Facility, if possible. However, in certain situations Kaiser also covers emergency care obtained from non-Plan providers. This coverage is described below. You pay any copayments that normally apply to the services you receive.

If your condition is an emergency and you are unable to call or go to a Kaiser Permanente facility, call 911 or go to the nearest hospital. Please be aware, however, that Kaiser will not pay for 911 ambulance and other non-Kaiser Permanente emergency medical services in their Southern California Service Area unless the additional time required to reach a Kaiser Permanente facility would result in death, serious disability, or significant jeopardy to your condition. Refer to your Kaiser disclosure information for further details about your emergency care benefit.

SERVICES RECEIVED AT A NON-PLAN FACILITY

To be eligible for this benefit, you must notify Kaiser Permanente within 48 hours after care begins (or as soon as reasonably possible). This benefit is provided only for emergency treatment required before your condition permits transfer to a Plan facility. Medically necessary special transportation is covered with prior approval from a Kaiser Plan Physician. Kaiser may arrange for your transfer to a Plan facility as soon as it is medically appropriate to do so. This benefit applies only to care that is a covered service under the Kaiser Plan Service Agreement.

SERVICES AT NON-PLAN FACILITIES OUTSIDE KAISER SERVICE AREA

Benefits are provided for immediate care needed because an unforeseen illness or injury occurs while you are outside the Kaiser Service Area, and services could not be delayed until you could get to a Plan Hospital or Plan Medical Office in the Service Area.

SERVICES AT NON-PLAN FACILITIES WITHIN KAISER SERVICE AREA

Benefits are provided for immediate care needed because of an unforeseen illness or injury if getting to a Kaiser Plan facility would have caused a delay resulting in death, serious disability, or significant jeopardy to your condition.

Converting to an Individual Policy - Contact Kaiser Directly

If coverage stops for you or for your eligible dependent because the eligible Employee no longer meets eligibility requirements, you and/or the eligible dependent may enroll in Kaiser's individual Plan.

Enrollment in the individual Plan is available during the 31-day period after coverage under the IBEW Local 40 - NECA Health Plan ends. If you enroll during this 31-day period, you may enroll without medical review, and your individual coverage will start on the date your coverage under this Plan ends.

When you are going to lose eligibility or when an eligible dependent will no longer be eligible to be covered with you, contact the Administrative Office for more information about converting to the individual Plan. Information is also available from the Kaiser Member Service Department.

Note: The individual Plan may not provide the same benefits you have under this Plan.

Coordination of Benefits by Kaiser

If you or your eligible dependents have medical coverage in addition to Kaiser Permanente, the other health care provider may have an agreement to participate in the payment of your medical expenses.

If you are also covered by another group health plan or insurance policy, Kaiser will coordinate benefits with the other plan or insurer. Under the COB rules of the California Commissioner of Corporations, Kaiser will work with the other plan or insurer to provide you with up to 100 percent of your covered medical expenses. Kaiser will decide under the COB rules, which coverage pays first, or is primary, and which coverage is secondary.
There are rules that determine which plan is primary coverage and which plan is secondary coverage. Primary coverage is the plan that pays first, and secondary coverage is the plan that pays second. Coordination of benefits rules have determined that if you are an employee and receive coverage from your own group insurance, then that plan is considered primary. Alternately, if your spouse receives benefits under your group insurance plan as a dependent and he or she is covered for benefits under their own group insurance plan as an employee, then the spouses insurance would be considered primary.

For your dependent children, the plan of the parent whose birth month and day occurs the earliest in the year will be primary. For example, if the father’s birthday is April 17 and the mother’s birthday is April 18, the father’s plan is primary and the mother’s plan is

secondary. For dependent children of divorced parents, the rules vary; Kaiser can provide you with those rules by calling their Member Service Call Center.

When Kaiser is secondary, your dual coverage may enable Kaiser to establish a Benefit Reserve Account for you.

The balance in your Benefit Reserve Account can be used for out-of-pocket medical expenses that were incurred during the calendar year in which services were received. To be reimbursed for expenses incurred outside Kaiser Permanente, an Explanation of Benefits from your primary coverage must be submitted. Additionally, documentation verifying payment of your or your dependent's out-of-pocket expense must be provided. To be reimbursed for Kaiser Permanente copayments, legible receipts indicating payment must be submitted.

When a Benefit Reserve Account has been set up for you, you will be provided with details of how to obtain reimbursement from it.

Kaiser Permanente will seek reimbursement from the patient if the patient is paid by the primary coverage for services received through Kaiser Permanente.

If you have questions on how coordination of benefits will effect your coverage under this plan you should contact the Kaiser membership services department at 1-800-443-0815 or hearing and speech impaired TDD line 1-800-777-1370, or on the internet at www.kaiserpermanente.org/california.

Third Party Liability

All work-related injuries and others responsible for your injury need to be documented. Under certain circumstances, others may be liable for medical expenses you incur.

Kaiser will provide you with services even if you were injured through the fault of someone else. If you collect any money from the other person or from his/her insurance company, you will be required to reimburse Kaiser (or its designee) at non-member rates for medical care Kaiser provided you for that injury or illness, up to the amount you (or your estate, parent, or court-appointed guardian) receive from the settlement or judgment. Kaiser shall have a lien on the settlement or judgment for the purpose of that reimbursement.

Payment will be made for covered emergency care services received from non-plan providers even if you were injured through the fault of someone else. If you collect any money from the other person or from his or her insurance company, you will be required to reimburse Kaiser (or its designee) for those payments Kaiser made for medical care provided to you for that injury or illness, up to the

amount you received from the settlement or judgment. Kaiser shall have a lien on the settlement or judgment for the purpose of that reimbursement.

At Kaiser's request, you shall execute lien forms directing your attorney or the other person to make payments directly to Kaiser from the proceeds of the settlement or judgment. If Kaiser institutes legal action to enforce its lien, the party that substantially prevails shall be reimbursed for the reasonable costs of collection, including attorney fees, by the other party(s).

This provision applies even if the total settlement or judgment you receive is less than your actual damages. It is your responsibility to notify Kaiser of any actual or potential claim or legal action you anticipate bringing or have brought against the other person within 30 days from the date of filing a claim or legal action against the other person.
Within 30 days after submitting or filing a claim for legal action against a third party, you must send written notice of the claim or legal action to:

Kaiser Permanente
Special Recovery Unit – 8553
Parson’s East and Floor
PO Box 7017
Pasadena, CA 91109-9977

A BRIEF SUMMARY OF KAISER HMO PLAN BENEFITS

The following chart is a summary of benefits only. For additional benefit information, refer to the disclosure information provided by Kaiser or call Kaiser directly from 7:00 a.m. to 7:00 p.m., seven days a week, toll-free at 1 (800) 464-4000.

Principal Benefits for Kaiser Permanente Traditional Plan (2/1/08—1/31/09)

The Services described below are covered only if all the following conditions are satisfied:

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

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year after the Copayments an Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family Unit of one Member)	$1,500 per calendar year
For any one Member in a Family Unit of two or more Members	$1,500 per calendar year
For an entire Family Unit of two or more Members	$3,000 per calendar year

Deductible or Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Primary and specialty care visits (includes routine and Urgent Care appointments)	No charge
Routine preventive physical exams	No charge
Well-child preventive care visits (0–23 months)	No charge
Family planning visits	No charge
Scheduled prenatal care and first postpartum visit	No charge
Routine preventive refraction exams	No charge
Routine preventive hearing tests	No charge
Physical, occupational, and speech therapy visits	No charge

Outpatient Services	**You Pay**
Outpatient surgery	No charge
Allergy injection visits	No charge
Allergy testing visits	No charge
Vaccines (immunizations)	No charge
X-rays and lab tests	No charge

Outpatient Services	You Pay
Health education:	
Individual visits	No charge
Group educational programs	No charge

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No charge

Emergency Health Coverage	You Pay
Emergency Department visits	$35 per visit (does not apply if admitted directly to the hospital as an inpatient)

Ambulance Services	You Pay
Ambulance Services	No charge

Prescription Drug Coverage	You Pay
Most covered outpatient items in accord with our drug formulary guidelines from Plan Pharmacies or from our mail-order program:	
Generic items	$5 for up to a 100-day supply
Brand-name items	$10 for up to a 100-day supply

Durable Medical Equipment (DME)	You Pay
Covered DME for home use in accord with our DME formulary guidelines	No charge

Mental Health Services	You Pay
Inpatient psychiatric care (up to 30 days per calendar year)	No charge
Outpatient visits:	
Up to a total of 20 individual and group visits per calendar year	No charge
Up to 20 additional group visits that meet the Medical Group criteria in the same calendar year	No charge per group visit

Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described i the *EOC*.

Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Outpatient individual visits	No charge
Outpatient group visits	No charge
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge

Other	You Pay
Eyewear purchased from Plan Optical Sales Offices every 24 months	Amount in excess of $350 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Hospice care	No charge

Other	You Pay
Chiropractic (up to 40 visits)	$5 copay

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing.

THE DELTA DMO DENTAL PLAN (DeltaCare)

Wrap around language. As a participant in this Plan, you are entitled to dental benefits under the Delta Dental Plan, provided you meet the eligibility requirements of the Plan.

Under the DeltaCare Plan, most covered benefits are provided for either no charge or for a fixed copayment, per procedure.

Importantly, under the DeltaCare Plan, you must select a dentist from the directory of dentists provided by Delta. In order to receive Plan benefits, you and your eligible family members must obtain all your dental care from the dentist you have selected. You are allowed to change to another panel dentist, because you move or prefer a change for other reasons.

The dentist you choose will be responsible for referring you to a specialist if that becomes necessary.

A BRIEF SUMMARY OF DELTA DMO DENTAL PLAN (DELTACARE) BENEFITS

The following chart is a summary of benefits only. For additional benefit information, refer to the disclosure information provided by PMI.

Plan 720 Codes	Procedures	Benefit (Cost to Participant)
	DIAGNOSTIC	
	Office visit, per visit (in addition to other services)	No Charge
0120	Periodic oral evaluation	No Charge
0140	Limited oral evaluation - problem focused	No Charge
0150	Comprehensive oral evaluation	No Charge
0160	Detailed and extensive oral evaluation - problem focused	No Charge
0210	Intraoral radiographs - complete series (Including bitewings)	No Charge
0220, 0230	Intraoral periapical film	No Charge
0240	Intraoral occlusal film	No Charge
0270. 0272, 0274	Bitewing radiograph(s)	No Charge
0330	Panoramic film	No Charge
	PREVENTIVE	
1110, 1120	Prophylaxis (cleaning) - adult/child - 1 per six month period	No Charge
1201	Topical application of fluoride, including prophylaxis (to age 19) - 1 per six month period	No Charge
1203	Topical application of fluoride, excluding prophylaxis (to age 19) - 1 per six month period	No Charge

Plan 720 Codes	Procedures	Benefit (Cost to Participant)
1330	Oral hygiene instruction	No Charge
1351	Sealant, per tooth	$5.00
1510	Space maintainer - fixed - unilateral	$10.00
1515	Space maintainer - fixed - bilateral	$10.00
1520	Space maintainer - removable - unilateral	$10.00
1525	Space maintainer - removable - bilateral	$10.00
1550	Recementation of space maintainers	No Charge
	RESTORATIVE (Fillings) *(Includes indirect pulp capping, bases, liners, and acid etch procedures)*	
2140	Amalgam - one surface, permanent	No Charge
2150	Amalgam - two surfaces, permanent	No Charge
2160	Amalgam - three surfaces, permanent	No Charge
2161	Amalgam - four or more surfaces, permanent	No Charge
2330	Resin - one surface, anterior	No Charge
2331	Resin - two surfaces, anterior	No Charge
2332	Resin - three surfaces, anterior	No Charge
2335	Resin - four or more surfaces or involving incisal angle	No Charge
2940	Sedative filling	No Charge
2951	Pin retention - per tooth, in addition to restoration	No Charge
	ORAL SURGERY *(Includes preoperative and postoperative evaluations and treatment under local anesthetic)*	
7111	Extraction, coronal remnants – deciduous tooth	No Charge
7210	Surgical removal of erupted tooth	$15.00
7220	Removal of impacted tooth - soft tissue	$25.00
7230	Removal of impacted tooth - partially bony	$50.00
7240, 7241	Removal of impacted tooth - completely bony	$70.00/90.00
7250	Surgical removal of residual tooth roots (cutting procedure)	No Charge
7286	Biopsy of oral tissue - soft	No Charge
7310	Alveoloplasty in connection with extractions, per quadrant	No Charge
7320	Alveoloplasty not in connection with extractions, per	No Charge
7470	quadrant	No Charge
7510	Removal of exostosis - maxilla or mandible	No Charge
7960	Incision and drainage of abscess - intraoral soft tissue	No Charge
	Frenulectomy - (frenectomy or frenotomy) separate procedure	
	PERIODONTICS *(Includes preoperative and postoperative evaluations and treatment under a local anesthetic)*	
4210	Gingivectomy or gingivoplasty, per quadrant	$80.00
4211	Gingivectomy or gingivoplasty. per tooth fewer than six teeth	$50.00
4220	Gingival curettage surgical, per quadrant	$10.00
4240	Gingival flap procedures including root planning,	$80.00
4260	Osseous surgery, flap entry and closure, per quadrant	$175.00
4341	Periodontal scaling and root planning, per quadrant	No Charge
4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis	No Charge

Plan 720 Codes	Procedures	Benefit (Cost to Participant)
4910	Periodontal maintenance (following active therapy)	No Charge
	PROSTHETICS	
	(Crowns, bridges, and dentures)	
2510	Inlay - one surface - base metal noble	No Charge
2520, 6520	Inlay - two surfaces - base metal noble	No Charge
2530, 6530	Inlay - three or more surfaces - base metal noble	No Charge
2543, 6543	Onlay - three surfaces - base metal noble	No Charge
2544, 6544	Onlay - four or more surfaces - base metal noble	No Charge
2710	Crown - resin (laboratory)	$35.00
2740	Crown - porcelain/ceramic +	$195.00
2750	Crown - porcelain fused to high noble metal * +	$195.00
2751	Crown - porcelain fused to predominantly base metal +	$95.00
2752	Crown - porcelain fused to noble metal +	$135.00
2790	Crown - full cast high noble metal *	$170.00
2791	Crown - full cast predominantly base metal	$70.00
2792	Crown - full cast noble metal	$110.00
2782	Crown - 3/4 cast metal noble	$110.00
2910	Recement inlay	No Charge
2920	Recement crown	No Charge
2930, 2931	Crown - prefabricated stainless steel - primary/permanent	No Charge
2950	Crown buildup (restorative material and pins)	No Charge
2952	Cast post and core * (in addition to crown)	No Charge
2954	Prefabricated post and core (in addition to crown)	No Charge
5110, 5120	Denture - complete maxillary or mandibular (upper or lower)	$100.00
5130, 5140	Immediate denture - maxillary or mandibular (upper or lower)	$120.00
5213, 5214	Denture - maxillary or mandibular (upper or lower) partial with metal lingual or palatal bar, clasps and acrylic saddles, and acrylic base or cast metal framework and teeth	$120.00
5410	Adjust complete denture - maxillary	No Charge
5411	Adjust complete denture - mandibular	No Charge
5421	Adjust partial denture - maxillary	No Charge
5422	Adjust partial denture - mandibular	No Charge
5510	Repair broken complete denture base	$15.00
5520	Replace missing or broken teeth - complete denture	$5.00
5610	Repair resin denture base	$15.00
5620	Repair cast framework	$15.00
5630	Repair or replace broken clasp	$15.00
5640	Replace broken teeth (per tooth)	$5.00
5650	Add tooth to existing partial denture	$5.00
5660	Add clasp to existing partial denture	$5.00
5730	Reline complete maxillary denture (chairside)	No Charge
5731	Reline complete mandibular denture (chairside)	No Charge
5740	Reline maxillary partial denture (chairside)	No Charge
5741	Reline mandibular partial denture (chairside)	No Charge
5710	Rebase complete maxillary denture	$35.00
5711	Rebase complete mandibular denture	$35.00
5720	Rebase maxillary partial denture	$35.00
5721	Rebase mandibular partial denture	$35.00
5750	Reline complete maxillary denture (lab)	$35.00

Plan 720 Codes	Procedures	Benefit (Cost to Participant)
5751	Reline complete mandibular denture (lab)	$35.00
5760	Reline maxillary partial denture (lab)	$35.00
5761	Reline mandibular partial denture	$35.00
5820	Interim partial denture (maxillary)	$45.00
5821	Interim partial denture (mandibular)	$45.00
5850, 5851	Tissue conditioning - per denture	No Charge
6210	Pontic - cast high noble metal *	$170.00
6211	Pontic - cast predominantly base metal	$70.00
6212	Pontic - cast noble metal	$110.00
6240	Pontic - porcelain fused to high noble metal * +	$195.00
6241	Pontic - porcelain fused to predominantly base metal +	$95.00
6242	Pontic - porcelain fused to noble metal +	$135.00
6750	Crown - porcelain fused to high noble metal * +	$195.00
6751	Crown - porcelain fused to predominantly base metal +	$95.00
6752	Crown - porcelain fused to noble metal +	$135.00
6790	Crown - full cast high noble metal *	$170.00
6791	Crown - full cast predominantly base metal	$70.00
6792	Crown - full cast noble metal	$110.00
6930	Recement bridge (fixed partial denture)	No Charge
6940	Stress breaker, per unit (in addition to mixed partial denture, retainer)	No Charge
6970	Cast post and core * (includes canal preparation)	No Charge
6972	Prefabricated post and core buildup (including Canal preparation, restorative material, and any pins)	No Charge
	ENDODONTICS	
3110, 3120	Pulp capping (direct/indirect)	No Charge
3220	Therapeutic pulpotomy (excluding final restoration)	No Charge
3310	Root canal therapy - anterior (excluding final restoration)	$45.00
3320	Root canal therapy - bicuspid (excluding final restoration)	$90.00
3330	Root canal therapy - molar (excluding final restoration)	$205.00
3410	Apicoectomy/periradicular surgery - anterior	No Charge
3421	Apicoectomy/periradicular surgery - bicuspid (first root)	No Charge
3425	Apicoectomy/periradicular surgery - molar (first root)	No Charge
3426	Apicoectomy/periradicular surgery - each additional root	No Charge
3430	Retrograde filling, per root	No Charge
3450	Root amputation, per root	No Charge
	ADJUNCTIVE GENERAL SERVICES	
9110	Palliative (emergency) treatment of dental pain	$5.00
9211	Regional block anesthesia	No Charge
9212	Trigeminal division block anesthesia	No Charge
9215	Local anesthesia	No Charge
9310	Consultation (diagnostic services provided by a dentist or physician other than practioner providing treatment)	No Charge
9440	Office visit after regularly scheduled hours	$20.00
0125	Failed appointment without 24 hour notification, per 15 minutes of appointment time	$10.00

Plan 720 Codes	Procedures	Benefit (Cost to Participant)
	ORTHODONTICS	
	Pre-treatment records and diagnostic services	$200.00
D8010	Limited orthodontic treatment of the primary dentition	$950.00
D8040	Limited orthodontic treatment of the adult dentition	$1,150.00
D8070	Comprehensive orthodontic treatment of the transitional dentition – *child or adolescent to age 19*	$1,700.00
D8080	Comprehensive orthodontic treatment of the transitional dentition – *adolescent to age 19*	$1,700.00
D8090	Comprehensive orthodontic treatment of adult dentition	$1,900.00

Please note the following concerning the DeltaCare Plan:

Any procedure not listed is available on a UCR (Usual, Customary, and Reasonable) basis.

The above procedures are performed as needed and deemed necessary by your attending network dentist subject to the limitations, exclusions, and governing administrative policies of the program.

- Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the enrollee at the additional laboratory cost of the high noble metal. This applies to crowns, bridges, cast and post cores, inlays and onlays.

- Porcelain on molars is considered optional treatment.

DISCLOSURE INFORMATION

DISCLOSURE INFORMATION
As required by the Employee Retirement Income Security Act of 1974 (ERISA)

1) **Name and type of administration of the Plan:**
IBEW Local 40 - NECA Health and Welfare Trust Fund, a collectively bargained, jointly-trusted labor-management Trust

2) **Name and address of the persons designated as agent for the service of legal process:**

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

Melissa Cook, Esq.
Cook and Associates
3444 Camino Del Rio North, Suite 106
San Diego, CA 92108

Service of legal process may also be made upon the Plan Trustees.

3) **Administrative Office of the Plan Administrator:**
Coast Benefits
3444 Camino Del Rio North, Suite 106
San Diego, CA 92108

Administrative Manager
Jonnette Tucker

4) **Names and addresses of the Trustees:**

Labor Trustees (IBEW Local 40)

Bill Brinkmeyer
IBEW Local Union 40
5643 Vineland Avenue

North Hollywood, CA 91601

Jerry McLinn
IBEW Local Union 40
5643 Vineland Avenue
North Hollywood, CA 91601

Dave Grabowski
IBEW Local Union 40
5643 Vineland Avenue
North Hollywood, CA 91601

Management Trustees (NECA)

James M. Willson
Los Angeles County Chapter NECA
675 S. Arroyo Parkway, Suite 300
Pasadena, CA 91105

Mike E. Richards
Los Angeles County Chapter NECA
675 S. Arroyo Parkway, Suite 300
Pasadena, CA 91105

Henry Turner
Los Angeles County Chapter NECA
675 S. Arroyo Parkway, Suite 300
Pasadena, CA 91105

5) **Source of financing of the Plan and identity of any of the organizations through which benefits are provided:**
Payments are made to the Trust by individual Employers under the provision of any of the Collective Bargaining Agreements.

The Trustees provide the following hospital/medical and dental programs by virtue of a contract with the Board of Trustees.

Kaiser Permanente (HMO)
Hospital/Doctor/Prescription Benefits
Delta Dental (DMO) Dental Benefits

6) **Date of the end of the Plan year:**
September 30

7) **Internal Revenue Service Plan Identification Number:**
EIN No. 95-4660513 Plan No. 501

8) **A description of the relevant provisions of any applicable collective bargaining agreement:**
The Plan is maintained pursuant to Collective Bargaining Agreements between IBEW Local #40 of the International Brotherhood of Electrical Workers, AFL-CIO and the L.A. County Chapter, National Electrical Contractors Association. Copies of Collective Bargaining Agreements may be obtained by Plan participants from the Union or Administrative Office at a reasonable charge upon written request. Additionally, Collective Bargaining Agreements may be examined by Plan participants at the Administrative Office of the Plan during regular business hours.

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

Claims Review and Appeals Procedure

If you have a problem with the service or benefits that you are receiving from Kaiser Permanente and/or Delta Dental the provider may have its own claims review or grievance procedure. You should contact the provider directly for its claims review or grievance procedure.

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.

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.

You may review any documents at the Administrative Office to help you in preparing your request, 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.

Statement of Rights

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

As a participant in the IBEW Local 40 - NECA Health and Welfare Trust Fund 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 Administrative Office and other specified locations, such as worksites and union halls, all documents governing the Plan, including, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund 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 Trustees may make a reasonable charge for each copy requested.

- Receive a summary of the Fund's annual financial report. The Trustees are 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 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 fund participants, ERISA imposes duties upon the people who are responsible for the operation of the Health 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 former Employers, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied 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 a suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a State or Federal court. If it should happen that Plan fiduciaries misuse the Plan's rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a 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 lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and legal fees.

Assistance with Your Questions

If you have questions pertaining to the Health Trust, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, 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 director or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.S. 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.

Notice to Participants

Providers Licensed By Department of Corporations

This applies to the following providers under contract with the Health Plan.

Kaiser HMO Plan
Delta Dental Plan

The California Department of Corporations is responsible for regulating health care service plans. The department has a toll-free telephone number (1-800-400-0815) to receive complaints regarding health plans. If you have a grievance against the health plan, you should contact the Plan and use the Plan's grievance process. If you need the department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved

by the Plan, you may call the department's toll-free number.