IBEW Local 40 - NECA Health and Welfare Plan

Summary Plan Description

For Eligible Active Participants
and their Eligible Dependents

Caution: This Summary Plan Description booklet should be kept together with the Evidence of Coverage booklets issued by Kaiser Permanente and Delta Dental (DeltaCare USA). Without the Evidence of Coverage booklets, this Summary Plan Description is not complete, and you should contact the Administrative Office or Kaiser or DeltaCare USA for another copy or copies.

Effective October 1, 2024

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GENERAL INFORMATION

Administrative Office

IBEW Local 40 - NECA Health and Welfare Trust Fund
Coast Benefits
3530 Camino del Rio North, Suite 110
San Diego, CA 92108

(800) 886-7559

Office Hours: Monday through Friday, 8:30 a.m. – 5:00 p.m., excluding holidays

Administrator: Jonnette Tucker, Coast Benefits

Board of Trustees

Labor Trustees
Stephan Davis
Tim Dixon
Peter Diamond

Management Trustees
Eric Cartier
Sean McKenna
Michael E. Richards

Alternates:
Juan Rodriguez

James Willson

Legal Counsel

Gilbert & Sackman, a Law Corporation

ASSISTANCE

This Summary Plan Description booklet ("SPD") contains a summary of your rights and benefits under the IBEW Local 40 - NECA Health and Welfare Plan.

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

Coast Benefits
3530 Camino Del Rio North, Suite 110
San Diego, CA 92108
Telephone: (800) 886-7559
Office Hours: Monday through Friday, 8:30 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 Kaiser Permanente, 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" for further information.

LETTER OF INTRODUCTION - Welcome!

To All IBEW 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 IBEW Local 40 – NECA Health and Welfare Plan, the Trustees are pleased to provide 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 for which you are eligible under the Plan.

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

- Kaiser Permanente HMO (health maintenance organization) medical plan
- Delta Dental DeltaCare USA DMO(dental maintenance organization) plan
- Delta Dental DeltaCare USA DPPO (dental preferred provider organization) plan
- Optum Employee Assistance Program

The Health Plan was established for you as a result of a collective bargaining agreement between IBEW Local 40 and the Los Angeles County 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 under the Plan 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 Trust Fund, contracts issued to the Trust Fund by Kaiser Permanente Plan, Delta Dental and Optum, as well as 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 at any time, in their sole and absolute discretion, change or terminate Plan benefits, eligibility requirements, or the Plan. The Board of Trustees' procedures for changing, enhancing, reducing, or eliminating benefits, are enumerated in the section entitled "Plan Amendment Procedures."

Any final decision concerning an individual's qualification for benefits under this Plan is made exclusively by the Board of Trustees. 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 and should not be considered authoritative.

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
October 1, 2024

DEFINITIONS

Annual Open Enrollment Period
Eligible Participants of the Plan are permitted to make a change in their choice of dental plans. Generally, the Open Enrollment period is held from September 15th through October 31st with plan changes effective December 1st. Participants who complete enrollment forms but do not select a plan will be automatically enrolled in the DeltaCare USA DMO Plan.

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 of 1986 (COBRA) and any changes or amendments to this law which may be enacted by law or regulation.

Collective Bargaining Agreement
Any agreement between the Association and IBEW Local 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 a Collective Bargaining Agreement.

Credited Hour
Credited hour means work hours reported under Covered Employment for which contributions are received by the Fund. The term "Credited Hour" also includes any hour that is worked by an employee under a health and welfare trust 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 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 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 which is a party to or obligated by a Collective Bargaining Agreement which requires contributions by the Employer into this Trust Fund. The term "Employer" also includes the Union.

Family Member
An Employee or dependent of an Employee.

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

HMO Hospital/Medical Plan
The Kaiser Permanente health plan provided under the Plan. Under the Kaiser HMO 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.

Plan
The IBEW Local 40 - NECA Health and Welfare Plan.

Qualifying Event
A qualifying event for COBRA 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 IBEW Local 40 - NECA Health and Welfare Plan participants, which contains all or substantially all of the information the average participant would deem crucial to a knowledgeable understanding of their 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 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 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 the section entitled "Cancellation of Eligibility & Termination of Hours Bank Reserve."

Working Local 40 Electricians

You will be eligible for benefits under the Plan on the first day of the third 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	January
November	February
December	March
January	April
February	May
March	June
April	July
May	August
June	September
July	October
August	November
September	December

Working Members who are Owners/Partners/Corporate Officers

Separate eligibility rules apply when an owner, partner, or corporate officer of an Employer participates in the Plan as a working member Local 40 electrician.

To be eligible for benefits under the Plan, as a working member, you must report a minimum of 160 hours per month. The employer contribution rate will be a flat monthly amount, based on 160 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 the Plan if they enroll within 60 days of signing a Collective Bargaining Agreement with the Union.

Working Local 40 members as described above, who may otherwise be eligible to participate in the 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 any time, 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 they are transferring.

Continuation of Eligibility – Hours Bank Reserve

WORKING LOCAL 40 ELECTRICIANS

Eligibility for benefits is continued on a month-to-month basis and is determined by the number of hours worked for an Employer. 120 hours worked equals one month of coverage. There is a full month between work month and coverage month. All hours worked are credited to your "Hours Bank" reserve account, up to a maximum of 720 hours which is equivalent to six months of coverage. 120 hours is deducted from your Hours Bank on the first day of each calendar month, for that month's coverage.

All hours worked in a month in excess of 120 hours will be added to your Hours Bank reserve account. The maximum number of hours you can accumulate in your reserve account is 720 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, their Hours Bank reserve will be terminated forty-five (45) days after the working member receives notice from the Trust Fund of the non-compliance if it has not been corrected in that forty-five day period.

Non-Bargaining Participation

The Board of Trustees has opened participation in the Plan to the non-bargaining staff of contractors who are parties to a Collective Bargaining Agreement. Participation in the Plan by non-bargaining staff is optional with the employer. If a contractor chooses to cover its non-bargaining staff, all full-time staff must be covered in accordance with rules determined by the Board of Trustees.

To participate in the Plan, a contractor will be required to pay monthly contributions for each eligible 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 employees, the employees may cancel that coverage and receive immediate eligibility under the Plan.

Kaiser Permanente provides HMO medical benefits, dental coverage is provided through Delta Dental, and Optum provides an employee assistance program.

New 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-Contributing 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 another IBEW-sponsored health plan.

Coverage for Employees will end on the earliest of the following dates:

- the last day of the month for which contributions are paid on your behalf or your Hours Bank terminates under the rules of the Plan
- the date the Employee enters full-time military service
- the date the Plan terminates

Eligible Dependents

Eligible dependents include:

- The legal spouse of the Employee. California and this Plan do not recognize common law spouses.

- The registered Domestic Partner of the Employee for whom the Plan receives a copy of the registered state Declaration of Domestic Partnership. Please note that coverage for a Domestic Partner is generally considered taxable under federal law. The Employee will be responsible for the payment of taxes related to the benefits provided in advance of the date benefits are granted.

- The Employee's child who has one of the following relationships to the Employee or the Employee's spouse: biological child, lawfully adopted child, child placed for adoption, or step-child for whom the Employee or spouse has been appointed the sole guardian. Dependent child coverage is provided to the last day of the month in which the child turns 26 years of age. (Eligible dependents do not include children of a Domestic Partner.)

- Unmarried dependent children 26 years of age or older, if the child is incapable of self-sustaining employment because of a mental or physical disability, receives 50% or more of their support from the Employee, and was disabled while covered under the Plan at the time they reached age 26. Proof of disability and dependency must be provided within 60 days of a written request.

Coverage for eligible dependents will end on the earliest of the following dates:

- the date the Employee's coverage ends
- the date the dependent enters full-time military service

- the date the Plan terminates or coverage for dependents ends
- for a spouse, upon dissolution, divorce, legal separation, or annulment.
- for a Domestic Partner, the date of termination of the Domestic Partner relationship.
- the date the dependent no longer meets the Plan's definition of an eligible dependent (for example, when a child ages out of coverage)

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, legal separation, divorce, or annulment as soon as it occurs. Additionally, you should notify the Administrative Office if your child reaches age 26. If a dependent is covered as an employee in an employer-sponsored group health plan, that plan will be primary to this Plan for coverage of the dependent child (see the section below entitled "Coordination of Benefits by Kaiser").

Electrical Industry Health and Welfare Reciprocal Agreement

Some Employees fail to qualify for health coverage under this Plan because they travel for work out of the geographic area covered by the Plan. In accordance with national guidelines, contributions received from another health and welfare trust fund that participates in the Electrical Industry Health and Welfare Reciprocal Agreement will be credited to the Employee as hours worked. To be eligible for health plan 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 (IBEW Local 40), the hours credited to the Employee will be pro-rated.

For example, if an Employee works 150 hours in a reciprocal area where the hourly health plan contribution rate is $8.00, and the Employee designates IBEW Local 40 as the home local, with a current hourly Plan contribution rate of $ 8.66, the hours will be pro-rated as follows:

Participating local rate $8.00 / Home local rate $8.66 = 92.4%
150 hours x 92.4% = 138.57 credited Health hours

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.

Extension of Coverage for Periods of Disability

If an eligible Employee is unable to work in Covered Employment as a result of a work-related illness or injury which occurs while working for an Employer, they may be credited with hours toward eligibility. In order to be eligible for this benefit, you must meet all of the following requirements:

1. You must have been eligible for Plan benefits in the month in which the occupational illness or injury occurred and contributions were paid to this Plan on your behalf by a contributing Employer.
2. You must give written notice of your illness or injury to the Administrative Office as soon as possible but no later than 30 days from the date you cease to be eligible under the Plan.

3. You must provide proof, satisfactory to the Board of Trustees, certifying your disability, and the time period of the disability.
4. You must provide proof that you are receiving state workers compensation benefits.
5. You must have been eligible for Plan benefits for the twelve consecutive month period prior to the month in which your disability occurred.
6. You do not have any hours bank reserve or insurance coverage in another group health plan which provides primary coverage for you.

You will be given 30 hours of work credit for each week of approved disability, up to a maximum of 6 months per disability.

Hours will be credited toward your eligibility, in the same manner as described above, under the section entitled "Eligibility." For example, if you are unable to work for three weeks in July, and have received 120 hours of disability credit, it will apply towards your November eligibility.

Solely for the purposes of establishing eligibility for the crediting of hours under this provision, hours worked for which contributions are being reciprocated to the Trust under the Electrical Industry Health and Welfare Reciprocal Agreement shall be considered hours worked in Covered Employment and the employer generating those reciprocal contributions shall be considered a contributing Employer to this Plan.

Coverage under this provision will run concurrently with any period of applicable COBRA coverage.

You will not be eligible to receive an additional extension of disability under this Section until you have had 24 months of active coverage under the Plan after any initial extensions of disability under this Section.

Termination or Reduction of Coverage

An Employee's coverage under the Plan will terminate on the earliest of any of the following:

A) The date the Employee enters military service in the Uniformed Services of the United States, as defined in the section below entitled "Credit for Military Service under the Uniformed Services Employment and Reemployment Rights Act (USERRA)."

B) The date the Employee loses eligibility under the Plan, including loss of eligibility as described in the section entitled "Cancellation of Eligibility & Termination of Hours Bank Reserve"; or

C) The date all coverage under the 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 an eligible dependent as provided below under the section entitled, "Eligible Dependents."

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

Qualified Medical Child Support Orders (QMCSOs)

As required by law, the Plan recognizes Qualified Medical Child Support Orders, called QMCSOs for short. A QMCSO is issued by the court in marital dissolution and divorce proceedings.
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."

In order for this Plan to recognize a QMCSO, the order must satisfy the following criteria:

1. It must be a judgment, decree or other court order relating to health benefits coverage for a child of a participant; and,
2. The order must specify the name and address of the participant; the name and mailing address of each child covered by the order; a reasonable description of the type of coverage afforded by the Plan; and the period for which the order applies.

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 with a copy of the order.
2) Within thirty (30) days after receipt of the order, the Administrative Office will notify you and the eligible dependent (through their custodial parent, guardian, or representative), in writing, if the order is recognized by the Plan as a QMCSO.
3) If the Plan determines that the order does not constitute a QMCSO, or additional information is required, you and the eligible dependent (through their custodial parent, guardian, or representative) will be notified in writing by the Plan.
4) If the Plan determines not to recognize the order as a QMCSO, 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.
5) If additional information is required, you will be notified what is needed and will have sixty (60) days to respond. If you do not respond within sixty (60) days, the request for recognition of the order as a QMCSO will be deemed cancelled.

Cancellation of Eligibility & Termination of Hours Bank Reserve

A participant who has accrued an Hours Bank under this Plan will lose their Hours Bank reserve and will not be eligible for further coverage under this Plan for their previously accrued Hours 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 another IBEW-sponsored group health plan.

The eligibility of a working member working in the capacity of owner, partner, or corporate officer, will be cancelled if such Employee is determined by the Trust Fund to be 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 member will terminate, and all Hours Bank reserve hours will be cancelled. Under certain circumstances, the working member may continue their health care coverage by making a self-payment. For further details, see the next section.

Special Enrollment Rights

Under federal law, you and/or your dependents are entitled to special enrollment rights if you declined coverage in this Plan because you and/or your dependents had other group health coverage and you lose that other group health coverage. Additionally, you are entitled to enroll a newly acquired dependent. However, you must request enrollment within 30 days of either the loss of the other coverage or the date you acquired the dependent to be eligible for this special enrollment right.

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

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

FEDERAL LAWS YOU SHOULD KNOW ABOUT

COBRA Continuation of Coverage

Introduction

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that the Plan offer you and your eligible dependents (except Domestic Partners) the opportunity to self-pay for a temporary extension of health care coverage at group rates in certain instances when coverage under the Plan would otherwise end (called a "qualifying event" under COBRA). Continued coverage under COBRA applies to the health care benefits described in this SPD: the benefits under COBRA are the same as those covering people who are not on continuation coverage. Each individual eligible for self-pay continuation coverage as the result of a COBRA qualifying event has a right to make their own election of coverage. For example, your spouse or other covered dependent may elect COBRA coverage even if you do not.

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

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. The Administrative Office will bill you each month for COBRA coverage, but it is your responsibility to make COBRA payments on time. If you do not make a 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 of: (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 day 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 1st.

You and your covered dependents 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 section entitled "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 (120) in your Hours Bank 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 for 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 maximum available coverage term for qualified beneficiaries to 36 months. Refer to the "Qualifying Events" section below. Also, Kaiser provides HMO-only Cal-COBRA coverage under California law, which provides coverage up to a maximum of 36 months if COBRA premiums are continually paid. In no event will federal COBRA and Cal-COBRA coverage exceed 36 months total.

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 & General Plan Provisions," under the subheading "Eligible Dependents." Also, children born or adopted by the covered employee during the period of COBRA continuation coverage are considered dependents, provided the employee enrolls the new child within 30 days of the 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 Kaiser HMO premium cost, plus 2% for administration. However, for a disabled qualified participant, the COBRA premium for coverage months 19 through 29 may be up to150% 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.

Q. *What is "basic" coverage?*

A. Basic coverage is Kaiser HMO hospital/medical ("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 (Kaiser) and dental (DeltaCare USA) coverage that is called "Core-Plus" or "Core-Full."

COBRA Eligibility

At a Glance – Qualifying Events That Entitle You to COBRA

The following table summarizes the COBRA coverage periods under different scenarios:

If you Lose Coverage Because of This Reason (a COBRA "qualifying event")	These People Will Be Eligible to Elect Self-Pay COBRA Coverage:	COBRA Coverage Maximum 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 no longer qualifies as an eligible dependent	Your covered child	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 disabled as determined by the Social Security Administration. This additional 11 months is available to employees and enrolled dependents if notice of disability is provided within 60 days after the Social Security determination of disability is issued and before the 18-month continuation period runs out. The cost of the additional 11 months of 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.

Also, you may be able to elect Cal-COBRA HMO-only coverage from Kaiser for an additional 18 months. In no event will federal COBRA and Cal-COBRA coverage exceed 36 months total. For more information about your rights under Cal-COBRA, contact Kaiser.

Employees

If you have established eligibility under the Plan, you have the right to choose COBRA continuation coverage for an initial 18 month continuation period if you lose health coverage under the Plan for any of the following reasons:

1. You lose your Plan coverage because of a reduction in your number of hours of covered employment.
2. Your employment is voluntarily or involuntarily terminated (for any reason other than gross misconduct on your part) with a contributing Employer as defined in the "Definitions" section of this booklet.

3. For employees on a Family and 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 under the Plan, you have the right to choose continuation coverage for yourself if you lose health coverage under the Plan for any of the following reasons:

1. Termination of your spouse's employment (for any reason other than gross misconduct) or reduction in your spouse's hours of employment (for an initial 18 month continuation period).

3. Your spouse's death (for an initial 36 month continuation period).
4. Divorce or legal separation from your spouse (for an initial 36 month continuation period).
5. Your spouse becomes eligible for Medicare (for an initial 36 month continuation period).

Children

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

1. Termination of your parent's employment (for reasons other than gross misconduct) or reduction in your parent's hours of employment (for an initial 36 month continuation period).
1. Parent's divorce or legal separation (for an initial 36 month continuation period).
2. Covered parent's death;
3. Covered parent becomes eligible for Medicare (for an initial 36 month continuation period).
4. You cease to be an eligible "dependent child" under the Plan rules (for an initial 36 month continuation period).

Required 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 one of these coverage-ending 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, and you and your dependents may be required to reimburse the Plan for costs or premiums incurred by the Plan for Plan coverage provided to ineligible individuals.

A COBRA 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, they may turn age 26 and cease to be an eligible dependent under Plan rules. If you do not notify the Administrative Office within 60 days of the date of the event, your dependents will not be entitled to elect continuation coverage.

When the Administrative Office is notified that one of these events has happened, the Administrative Office will, within 14 days, inform you in writing of your right to choose COBRA continuation coverage. The Plan's 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 of the following: (1) the date the Plan's COBRA notice is sent to you, or (2) the date your regular Plan coverage terminates.

Children born or adopted by the covered employee during the period of continuation coverage are considered dependents, provided the employee enrolls the new child within 30 days of the birth or adoption. 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 and you will not be able to elect COBRA continuation coverage at a later date.

Benefits and Length of COBRA Coverage

If you choose "Basic" continuation coverage, it will be the same HMO hospital/medical coverage (under 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, the Employee or their dependent(s) are determined to be disabled by 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 maximum eligible coverage term for qualified beneficiaries to 36 months.

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 COBRA continuation coverage be more than 36 months.

If you are enrolled in Kaiser, you can elect Cal-COBRA from your HMO for an additional 18 months after the loss of federal COBRA coverage. In no event will federal COBRA and Cal-COBRA coverage 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. Your Employer or former Employer no longer participates in the Plan.
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. 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.

5. 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.
6. You become entitled to Medicare benefits **after** COBRA coverage has been elected.
7. You are no longer disabled. If a qualified beneficiary is determined to no longer be disabled by the Social Security Administration 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.
8. This Plan is terminated.

Cost of Continuation Coverage

The cost of continuation coverage is based on the Kaiser medical plan in which you are enrolled as of the date of the qualifying event. You can choose between Basic Coverage which will be Kaiser only, or the whole plan of benefits which includes the dental plan provided through Delta Dental.

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 should write or phone the Administrative Office to receive a copy of the cost sheet that provides the continuation rates that apply to you. The phone number and address are shown on the first page of this SPD 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 December 31st: there is no coverage for January. Keep in mind that, while the Administrative Office does send monthly bills for COBRA coverage, it is your responsibility to see that your payment is received by 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 30th). 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.

The Administrative Office will notify you 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.

Privacy of Health Information - HIPAA

A federal law, the Health Insurance Portability and Accountability Act (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, requires that the Plan maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI). A complete description of your rights under HIPAA will be found in the Plan's Privacy Statement included in this section.

Since the Plan is required to keep your PHI confidential, before the Plan can disclose any of your PHI to the Board of Trustees, which acts as the sponsor of the Plan, the Trustees must also agree to keep your PHI confidential. In addition, the Trustees must agree to handle your PHI in a way that enables the Plan to follow the rules in HIPAA.

The Board of Trustees agrees to the following rules in connection with your protected health information:

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

- Unless it has your written permission, the Board will only use or disclose PHI for that plan administration, or as otherwise permitted by this SPD, or as permitted or required by law.

- The Board will not disclose your PHI to any of its agents or subcontractors unless the agents and subcontractors agree to handle your PHI and keep it confidential to the same extent as is required of the Board of Trustees in this SPD.

- The Board will not use or disclose your PHI 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 will allow you, through the Plan, to inspect and photocopy your PHI, to the extent, and in the manner, required by HIPAA.

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

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

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

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

    - These individuals will be permitted to have access to and use the PHI 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 PHI that violates the rules set forth in this SPD. If the Board becomes aware of any such violations, the Board 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 will make available to the Secretary of Health and Human Services its internal practices, books and records relating to the use and disclosure of PHI received from the Plan in order to allow the Secretary to determine the Plan's compliance with HIPAA.

- The Board will return to the Plan or destroy all your PHI received from the Plan when there is no longer a need for the information. If it is not feasible for the Board to return or destroy the PHI, then the Trustees will limit their further use or disclosures of any of your PHI 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 SPD is a section entitled "Plan Amendment Procedures" which explains the notice you will receive if there is a material reduction in benefits. The 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 Plans – DeltaCare USA DMO and Delta Dental PPO

    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

HIPAA Privacy Notice

➢ 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 Health Fund has contracted with Kaiser Permanente to provide your medical benefits and has contracted with Delta Dental (DeltaCare USA) to provide dental benefits. HIPAA and state 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 PHI you should contact them directly.

Business Associates: There are some services provided by the Trust Fund through contracts with business associates. When these services are contacted, we may disclose your PHI 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 PHI 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 PHI to provide health and welfare services to you. We may, without authorization but only as permitted or required by law, provide PHI to persons or organization both inside and outside of the Trust Fund for the purposes stated below:

- 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,
- distribution of health related benefits and services,
- public health activities
- to the Plan sponsor (the Board of Trustees),
- when legally required,
- organ and tissue donation
- conduct health oversight activities,
- in connection with judicial and administrative proceedings
- 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 state workers compensation purposes,
- to individual(s) involved in your care or payment of your care,
- for Department of Health and Human Services (HHS) investigations and to business associates.

➢ How Do We Protect Your Protected Health Information?

Protected health information within the Trust Fund is only available to those individuals who need to see it to fulfill and service your needs. All employees and agents of the Trust Fund are instructed on the need to protect PHI. In addition, we've established legal agreements with companies working on the Trust Fund's behalf that require them to protect PHI and to use that information only to provide the service we have asked them to perform. Should your relationship with the Trust Fund end, your PHI 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

You have the following rights regarding the health information the Plan maintains about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your protected health information (PHI). This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

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

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

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

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

  - For Treatment, Payment or Health Care Operations;
  - To you about your own health information;
  - Incidental to other permitted or required disclosures;
  - Where authorization was provided;
  - To family members or friends involved in your care (where disclosure is permitted without authorization);
  - For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
  - As part of a "limited data set" (health information that excludes certain identifying information).

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

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

- **Right to Request Restrictions.** You have the right to request a restriction on the health information the Plan uses or disclosures about you for treatment, payment or health care

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

To request restrictions, make your request in writing to the Plan. You must advise 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.

  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. 101
  San Diego CA 92108

  If you believe your privacy rights have been violated, you can file a complaint with 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 that the Trust Fund may periodically update or revise this Privacy HIPAA Privacy Notice. If we change our Privacy Notice, a new notice will be sent to you. If you have any questions or would like more information, please don't hesitate to call the **Administrative Office for the Trust Fund at (800) 886-7559.**

Your Rights under the Newborns' and Mothers' Health Protection Act

A federal law called the Newborns' and Mothers' Health Protection Act (Newborns Act) provides 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 the 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.

Your Rights under the Women's Health and Cancer Rights Act

A federal law called the Women's Health and Cancer Rights Act (WHCRA) 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 Women's Health and Cancer Rights Act

Q. *I've been diagnosed with breast cancer and plan to have a mastectomy. How does 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 lymph edemas.

Q. *Does 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.

Your Rights under the Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. However, there is no requirement that health plans even provide mental health benefits. The Plan complies with the MHPAEA, as modified from time to time.

The mental health and substance use disorder benefits available under the Plan are provided through Kaiser. The Evidence of Coverage booklet you receive from Kaiser has a complete explanation of these 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 Trust Fund Administrative Office.

Credit for Military Service under the Uniformed Services Employment and Reemployment Rights Act (USERRA)

A federal law called the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides protections to eligible individuals who serve in the "Uniformed Services" of the United States, which includes the Army, the Navy, the Marines, the Coast Guard, 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 of the United States in time of war or 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 their employment, and the period of military leave is less than thirty-one (31) days, the Employee and their Dependents will continue to be eligible for health care coverage under this Plan during the leave with no self-payment required, provided they are eligible for benefits under this Plan at the time their 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 their employment, and the period of military leave is for more than thirty (30) days, USERRA permits the Employee to continue coverage for the Employee and their Dependents at their own expense. The cost is 102% of the Fund's cost of benefits for up to 24 months so long as the Employee gives the Fund Administrative Office advance notice of the leave (with certain exceptions), and so long as the Employee's 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); (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 they return to work as if they had not taken leave or as of the date of registration for employment through the Union, provided they are eligible for re-employment under the terms of USERRA and provided they return 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 their period of service.

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

5. If the Employee does not return to work at the end of their military leave, they may be eligible to purchase COBRA continuation coverage under the Plan provided they give 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.

Your Rights under the Family and Medical Leave Act

Under a federal law called the Family and Medical Leave Act (FMLA), Employers who employ fifty or more persons within a seventy five (75) mile radius of the worksite are required to maintain health coverage for their Employees under certain circumstances. If you have been employed for such an Employer for a minimum of twelve months, and have worked at least 1,250 hours over the last twelve month period, you may be eligible to continued health coverage under this Plan for up to twelve weeks (in some cases, up to 26 weeks) during any twelve month period for one or more of the following events:

1. The birth of a child of an Employee;
2. Adoption of a child by an Employee or placement of a child in the foster care of an Employee;
3. Serious illness of an Employee or of a child, spouse, or parent of an Employee; or
4. A qualifying exigency, as determined by the Secretary of Labor, arising out of the fact that your spouse, child, or parent is on active duty in the Armed Forces in support of a contingency operation.

The service requirements must be met by your work for a single employer. If you worked for more than one Employer, you cannot combine your work history under all the Employers for whom you worked to meet the service requirements outlined above. For more information on the FMLA service requirements, contact your Employer.

An Employee's Employer is responsible for maintaining contributions to the Trust on behalf of the Employee for the Employee's health coverage to continue while the Employee is on FMLA leave. It shall be the responsibility of the Employee to notify the Administrative Office that leave is taken under the FMLA, as well as the commencement date of such leave and the duration. If the Employee is entitled to continued health coverage under the FMLA, so long as required monthly contributions are received by the Plan from the Employee's Employer the Plan is required to provide coverage which, as of the time coverage is provided, is identical to the coverage provided to the Employee at the same level and under

the same conditions as coverage would have been provided if the Employee were still working. COBRA continuation coverage is available if the Employee does not return to work after an approved FMLA leave.

The Trustees and the Plan are not responsible for determining whether an individual Employee is eligible for FMLA benefits. Disputes as to the entitlement to FMLA benefits must be resolved by the Employee, the Employer and, where applicable, the Union.

If you have any questions about your rights under the Family and Medical Leave Act, feel free to contact the Administrative Office.

PLAN AMENDMENT PROCEDURES

Changing, Enhancing, Reducing, or Eliminating Benefits

There is no vested right to receive Plan benefits. This means that the Board of Trustees may change, enhance, reduce, or eliminate benefits, eligibility requirements, even the Plan itself, at any time, in its sole and absolute discretion. 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 of benefits. 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 to Participants of Plan Changes

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

You will be provided a written notice when such changes to the Plan 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 MEDICAL PLAN

Basic Information

As a participant in this Plan, you are entitled to medical, hospital, surgical, 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 dependents. Referrals to certain specialists may require a referral by your Kaiser doctor.

Complete benefits and information about the Kaiser plan are described in Kaiser's descriptive literature or call the Kaiser customer service call center at (800) 464-4000. The services provided by Kaiser 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 here 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 Kaiser HMO plan.

Emergency Care and Urgent Care

Emergency care and urgent care are available from Kaiser 24 hours a day, 7 days a week. All necessary care, emergency or otherwise, should be obtained at a Kaiser plan facility, if possible. However, in certain situations Kaiser also covers emergency care obtained from non-Kaiser 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 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 emergency medical services in Kaiser's Southern California service area unless the additional time required to reach a Kaiser 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-Kaiser Facility Within the Kaiser Service Area

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 Kaiser 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 Received at Non-Kaiser Facilities Outside the 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, provided services could not be delayed until you could get to a Kaiser hospital or medical office in the Kaiser service area.

Converting to an Individual Kaiser 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 a Kaiser 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 they are covered for benefits under their own group insurance plan as an employee, then the spouse's 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.

If a dependent child is covered as an employee in an employer-sponsored group health plan, that plan will be primary to this Plan for coverage of the dependent child.

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

If you have questions on how coordination of benefits will affect your coverage under the Kaiser HMO plan you should contact the Kaiser membership services department at (800) 443-0815 or the hearing and speech impaired TDD line at (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 their 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-Kaiser providers even if you were injured through the fault of someone else. If you collect any money from the other person or from their 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 must 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 or parties.

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
Harrington Health
PO Box 30547
Salt Lake City, UT
84130-0547

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 (800) 464-4000.

Principal Benefits for the Kaiser HMO Plan (Kaiser Permanente Traditional Plan)

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 and 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
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 in 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)	No charge

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
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 DELTACARE USA DMO DENTAL PLAN (GROUP NO. 72390)

As a participant in this Plan, you are offered a dual choice of dental plans provided by Delta Dental. You must meet the eligibility requirements of the Plan.

Whatever plan choice you select, DeltaCare USA DMO Plan or Delta Dental PPO Plan, all family members need to be enrolled in the same plan. If you do not select one of the two available plans you will be automatically be enrolled in the DMO Plan. You will only be allowed to change your choice of plans once each year, during the annual open enrollment period. Normally, information on the open enrollment is mailed out in September of each year and any change in dental plans must be made and received in the Administrative Office by October 31st. Plan changes are effective with the eligibility period starting December 1.

A brief summary of the benefits for each plan are described separately below.

A Brief Summary of DeltaCare USA DMO Dental Plan Benefits

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

Importantly, under the DeltaCare USA DMO Plan, you must select a dentist from the directory of dentists provided by DeltaCare USA. 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, if 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.

The following chart is a summary of benefits only. For additional benefit information, refer to the disclosure information provided by Delta Dental for its DeltaCare USA DMO Dental Plan.

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

Plan 720 Codes	Procedures	Benefit (Cost to Participant)
	PREVENTIVE	
1110, 1120	Prophylaxis (cleaning) - adult/child - 1 per six month period	No Charge
1206,1208	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
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
1551, 1552	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 quadrant	No Charge
7471	Removal of exostosis - maxilla or mandible	No Charge
7510	Incision and drainage of abscess - intraoral soft tissue	No Charge
7961, 7962	Frenulectomy - (frenectomy or frenotomy) separate procedure	No Charge
	PERIODONTICS *(Includes preoperative and postoperative evaluations and treatment under a local anesthetic)*	
4210	Gingivectomy or gingivoplasty, per quadrant	$80.00

Plan 720 Codes	Procedures	Benefit (Cost to Participant)
4211	Gingivectomy or gingivoplasty. per tooth fewer than six teeth	$50.00
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
4910	Periodontal maintenance (following active therapy)	No Charge
	PROSTHETICS *(Crowns, bridges, and dentures)*	
2510	Inlay - one surface - base metal noble	No Charge
2520	Inlay - two surfaces - base metal noble	No Charge
2530	Inlay - three or more surfaces - base metal noble	No Charge
2543	Onlay - three surfaces - base metal noble	No Charge
2544	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
5511, 5512	Repair broken complete denture base	$15.00
5520	Replace missing or broken teeth - complete denture	$5.00
5611, 5612	Repair resin denture base	$15.00
5621, 5622	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

Plan 720 Codes	Procedures	Benefit (Cost to Participant)
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
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
	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

Plan 720 Codes	Procedures	Benefit (Cost to Participant)
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 practitioner providing treatment)	No Charge
9440	Office visit after regularly scheduled hours	$20.00
	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	
D8090	– *adolescent to age 19*	$1,700.00
	Comprehensive orthodontic treatment of adult dentition	$1,900.00

Please note the following concerning the DeltaCare DMO Dental 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 an optional treatment.

THE DELTA DENTAL PPO PLAN (GROUP NO. 18425)

The Delta Dental PPO plan provides the maximum benefit when you visit a PPO dentist. PPO dentists are dentists who have agreed to charge PPO patients reduced fees.

Under the PPO plan there is a twelve-month waiting period for major restorations including crowns/prosthodontic services and dentures.

The Delta Dental PPO plan includes the following features:

- You save on out-of-pocket expenses when you visit a PPO network dental office.
- You can visit any licensed dentist of your choice – select a different dentist for each member of your family.
- You can change dentists at any time.
- You can go to a dental specialist of your choice.
- You can receive dental care anywhere in the world.

Under the PPO plan, you may visit any licensed dentist you wish. However, you receive the maximum benefits available under the program when you choose a PPO dentist

Below is a brief summary of the Delta Dental PPO benefits:

A Brief Summary of Delta Dental PPO Plan Benefits

When Treatment is Provided by:	**In-Network Preferred Option Dentist (PPO)**	**Premier and Out-of-Network Dentist**
Who's Covered	Eligible employee and spouse as well as dependent children to age 26	Eligible employee and spouse as well as dependent children to age 26
Deductibles/Maximums Calendar Year Deductible Annual Family Deductible Maximum Benefits per year	 $25 per person $75 per family $1500 per person	 $50 per person $150 per family $1500 per person
BENEFIT COVERAGE:		
Diagnostic and Preventive Benefits* Oral Examinations Prophylaxis (cleanings) X-rays Examination of Tissue Biopsy Fluoride Treatment Space Maintainers Specialist Consultation	100% of PPO approved fee	100% of Delta approved fee
Basic Benefits** Oral Surgery (extractions) Restorative (fillings)	80% of PPO approved fee	80% of Delta approved fee

When Treatment is Provided by:	In-Network Preferred Option Dentist (PPO)	Premier and Out-of-Network Dentist
Endodontics (root canal therapy) Periodontics (treatment of gums and bones supporting teeth) Sealants		
Crowns, Jackets, and Cast Restorations* For treatment of carious lesions (visible destruction of hard tooth structure resulting from dental decay) which cannot be restored with amalgam, synthetic or plastic restorations	50% of PPO approved fee	50% of Delta approved fee
Prosthodontic Benefits Bridges (fixed and removable) Partial Dentures (subject to a maximum allowance) Full Dentures (subject to a maximum allowance)	50% of PPO approved fee (subject to a maximum allowance)	50% of Delta approved fee (subject to a maximum allowance)
Orthodontic Benefit* - for adults and eligible dependent children	None	None
* Please refer to your Evidence of Coverage for limitations on these benefits. Some examples of limitations on services are the number of cleaning and oral exams covered in a calendar year, and time limitations on filling and crown replacements. ** DeltaCare USA endodontists, oral surgeons, and periodontists are not PPO dentists, but you receive in-network benefits when visiting one of these specialists.		

How to Use the Delta Dental PPO Program

To use the Delta Dental PPO Program, call the dental office of your choice and make an appointment. During your first appointment, give your dentist the following information:

- Identify yourself as eligible for benefits under the IBEW Local 40 - NECA Health and Welfare Plan, Delta Dental group number 18425.
- The employee's social security number.

When you call a Delta Dental PPO dentist for an appointment, please confirm that the dentist participates in the PPO network.

The Administrative Office has a complete list of PPO dentists and DeltaCare USA dentists. The toll-free number for DeltaCare USA is (800) 422-4234 to determine if a particular dentist participates in the DeltaCare USA Program. You can call toll-free at (800) 765-6003 for a list of Delta Dental PPO dentists in your area. You may also visit the Delta Dental website at www.deltadentalins.com.

OPTUM EMPLOYEE ASSISTANCE PROGRAM (EAP)

As a participant in the IBEW Local 40 - NECA Health and Welfare Plan, you are eligible for benefits under the Optum employee assistance program (EAP) called Emotional Wellbeing Solutions, at no cost to you. EAP benefits are available to all members of your household, including children living away from home.

EMOTIONAL WELLBEING SOLUTIONS is available 24/7 at no cost to you.

This includes referrals, seeing network providers, access to Optum's Live and Work Well website (**liveandworkwell.com)**, where you can find care and support for your emotional wellbeing and set up initial consultations with mediators or financial and legal experts.

Help is available over the phone or online, anytime.

Emotional Wellbeing Solutions specialists are available by phone to provide help with a range of life concerns and stressors, including:

*Relationship problems

*Workplace conflicts and changes

*Parenting and family issues

*Eldercare support

*Stress, anxiety & depression

*Legal and financial concerns

You can also access six counseling visits, either in person or virtually, with a provider in the Optum network – at no cost. All conversations are confidential, and we never share your personal records with your employer or anyone else without your permission.

For further information, call *866) 248-4094 or sign into liveandworkwell.com. Register with your Healthsafe ID or enter the access code IBEW40 to find the right support for you.

DISCLOSURE INFORMATION 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 fund

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

Coast Benefits
3530 Camino Del Rio North, Suite 110
San Diego, CA 92108

Steven M. Rehaut, Esq.
Gilbert & Sackman, a Law Corporation
800 Wilshire Boulevard, Suite 1410
Los Angeles, CA 90017

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

3) **Administrative Office of the Plan Administrator:**
Coast Benefits
3530 Camino Del Rio North, Suite 110
San Diego, CA 92108

Administrative Manager: Jonnette Tucker

4) **Names, addresses, and phone numbers of the Trustees:**

Labor Trustees
Stephen Davis
IBEW Local 40
5643 Vineland Avenue
North Hollywood, CA 91601
Phone: 818-762-4239

Tim Dixon
BEW Local 40
5643 Vineland Avenue
North Hollywood, Ca 91601
Phone: 818-762-4239

Management Trustees
Eric Cartier
Los Angeles County Chapter NECA
100 E. Corson Street, Suite 410
Pasadena, CA 91105
Phone: 626-792-6322

Michael E. Richards
Los Angeles County Chapter NECA
100 E. Corson Street, Suite 410
Pasadena, CA 91105
Phone: 626-792-6322

Peter Diamond
IBEW Local 40
5643 Vineland Avenue
North Hollywood, CA 91601
Phone: 818-762-4239

Sean McKenna
Los Angeles County Chapter NECA
100 E. Corson Street, Suite 410
Pasadena, CA 91105
Phone: 626-792-6322

Alternates:

Juan Rodriguez
IBEW Local 40
5643 Vineland Avenue
North Hollywood, CA 91601
Phone: 818-762-4239

Jim Willson
Los Angeles County Chapter NECA
100 E. Corson Street, Suite 410
Pasadena, CA 91105
Phone: 626-792-6322

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 – DeltaCare USA DMO and Delta Dental PPO Dental Benefits
Optum – Employee Assistance Program (EAP)

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 Local 40 of the International Brotherhood of Electrical Workers, AFL-CIO and the Los Angeles County Chapter of the National Electrical Contractors Association. Copies of Collective Bargaining Agreements may be obtained by Plan participants from the Union or Administrative Office 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: both Kaiser and Delta Dental have procedures that allow you to appeal any claim(s) that are denied. For further information, contact Kaiser or Delta Dental.

Claims Review and Appeals Procedures

The following claims and appeals rules apply to claims and appeals regarding eligibility under the Plan or eligibility for Plan benefits. If you have a problem with the service or benefits that you are receiving from Kaiser Permanente or Delta Dental (DeltaCare USA), the provider has its own claims review or grievance procedure. You should contact the provider directly for its claims review and appeals procedures.

Denial of Eligibility

All denials of eligibility under the Plan will be handled by the Administrative Office in accordance with the provisions stated below. A claim will be considered denied if the participant or dependent is notified, in writing that their eligibility is denied.

In the event of a denial of eligibility by the Administrative Office, the claimant or their representative will be notified in writing of such denial, setting forth the specific reason or reasons for the denial of eligibility, and a specific reference to the provisions of the Plan or other documents which are the basis for the denial of eligibility for Plan benefits.

Request for Review

The Administrative Office will notify the claimant, in writing, if additional information is necessary in order to perfect the claim. This notification will specify what information or materials are necessary and explain why they are necessary. This written notice denying eligibility will explain the Plan's review procedure and will also state that the claimant or their representative may request a review of the denial of eligibility by submitting, within 60 days from the mailing of such notice of eligibility denial, a written statement setting forth the following matters:

(A) A statement that the claimant wishes review of the determination denying their eligibility;
(B) A statement setting forth each and all ground upon which the claimant's request for review of the denial of eligibility is based;
(D) Any documents and writings which are relevant to the request for review of the denial of the claim; and
€ A statement by the claimant that the information contained and request for review is true to the best of the claimant's knowledge.

Timely Requests

A written statement requesting a review of denial of a claim for eligibility will be deemed to be timely if the date of postmark to the Administrative Office is within 60 days of the date of mailing of the written notice of the denial by the Administrative Office. You will be deemed to waive your appeal rights if you fail to timely request a review.

Board of Trustees Appeals Procedures

All requests for review will be considered by the Trustees. The Administrative Office will, after receiving the claimant's request for review, submit the claimant's written statement to the Trustees, together with a written report summarizing the facts underlying the claim for denial of eligibility.

A full and fair review of each request will be granted by the Trustees. On the basis of its review, the Trustees will make an independent determination of the claimant's eligibility under the Plan.

The Trustees will notify the claimant within 60 days after the written request for review unless special circumstances require an extension. If special circumstances require an extension, the claimant will be notified of the decision of their request within 120 days after receipt of such request.

The Trustees shall have full discretionary authority to interpret and decide all matters concerning the Plan and 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 Employee Benefit Plan Claims Arbitration Rules 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 have the right to file a civil action in court under Section 502(a) of ERISA, challenging a denial of eligibility for benefits under this Plan, in whole or in part, after you have exhausted your administrative remedies including arbitration.

Statement of Rights under ERISA

As a participant in the IBEW Local 40 - NECA Health and Welfare 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.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Notice to Participants Regarding Providers Licensed by the California Department of Corporations

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

Kaiser Permanent (Kaiser HMO Plan)
Delta Dental (DeltaCare USA DMO Plan and Delta Dental PPO Plan)

The California Department of Corporations is responsible for regulating health care service plans. The department has a toll-free telephone number, (800) 400-0815, to receive complaints regarding health plans. If you have a grievance against the 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.