

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

Dear Participant:

This booklet summarizes the benefits offered by the I.B.E.W. Local 332 Health and Welfare Plan effective January 1, 2004.

Eligible Active Employees may choose among four different medical programs: medical benefits paid directly by the Plan, benefits provided by the Kaiser Foundation Health Plan, benefits provided by the Health Net Plan, or benefits provided by PacifiCare of California. You may change the medical program covering yourself and your eligible family members during the annual open enrollment period between October 1 and October 31. Provided your change request is received within the time allowed, your new coverage will become effective on January 1. The Plan also provides dental, vision care, short-term disability, life insurance, and accidental death and dismemberment benefits.

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

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

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

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

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

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

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

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

### **HELP PREVENT WASTE AND FRAUD**

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

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

Your Plan takes fraud very seriously. All claims are checked to ensure the patient is eligible and the treatment was received. The Trustees require a full refund of any benefit payment obtained by fraud, with interest and legal costs. Any incident involving fraud also may be referred to the authorities for criminal prosecution. Attempting to defraud a health plan is a crime under both Federal and state laws, even if the fraud is detected and the plan is not actually harmed.

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

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

Sincerely,

**THE BOARD OF TRUSTEES**

**TELEPHONE/WEBSITE REFERENCE GUIDE**

<p><b>ELIGIBILITY, PREMIUMS, RESERVE AMOUNTS AND INFORMATION BOOKLETS</b></p>	<p>United Administrative Services (Plan Administrator's Office) (408) 288-4452 Toll-Free: (800) 541-8059</p>
<p><b>SELF-FUNDED MEDICAL PLAN DENTAL PLAN</b></p>	<p><b>For questions about claim payment, claim forms and benefit information call:</b>  Plan Administrator's Office (408) 288-4481 Toll-Free: (800) 541-8059</p>
<p><b>BLUE CROSS PPO</b></p>	<p><a href="http://www.bluecrossca.com">www.bluecrossca.com</a>  <b>To locate a participating preferred provider physician, clinic or hospital call:</b>  (408) 288-4452 Toll-Free: (800) 541-8059 (Refer to Group # 170017)</p>
<p><b>INTERPLAN/DENTINEX DENTAL PPO</b></p>	<p><a href="http://www.interplancorp.com">www.interplancorp.com</a>  <b>To locate a participating preferred provider dentist call:</b>  Toll-Free: (800) 444-4036</p>
<p><b>KAISER PERMANENTE</b></p>	<p><a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a>  <b>For questions about benefit information and ID Cards call:</b>  Toll-Free: (800) 464-4000 (Refer to Group # 780)</p>
<p><b>HEALTH NET</b></p>	<p><a href="http://www.health.net">www.health.net</a>  <b>For questions about benefit information and ID Cards call:</b>  Toll-Free: (800) 522-0088 (Refer to Group # 57826)</p>
<p><b>PACIFICARE</b></p>	<p><a href="http://www.pacificare.com">www.pacificare.com</a>  <b>For questions about benefit information and ID Cards call:</b>  Toll-Free: (800) 624-8822 (Refer to Group # 140167)</p>
<p><b>VISION SERVICE PLAN</b></p>	<p><a href="http://www.vsp.com">www.vsp.com</a>  <b>For questions about vision benefits and vision claims or to request a Vision Plan Provider Directory call:</b>  Toll-Free: (800) 877-7195</p>

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Updated January 1, 2004**

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# ELIGIBILITY

## **Eligibility**

You are eligible for benefit coverage if you are employed under the jurisdiction of the Union as a member of the bargaining unit or working member of the firm or of the Union and if sufficient contributions have been made in your name by participating employers.

## **Active Employees**

You and your eligible Dependents will be covered on the first day of the second month following the last day of any month in which you have accumulated a reserve of \$600, and if contributions have been made and received in your name for the hours you have worked for one or more participating employers.

On the first day of the calendar month preceding each month for which you are covered, \$600 is deducted from your reserve accumulation. The \$600 deduction covers life, accidental death and dismemberment, short-term disability and hospital, medical, surgical, dental and vision benefits. Effective January 1, 2004, your maximum accumulated reserve can be \$7,200 (12 months), which would be after the monthly deduction.

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

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

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

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

## **Residual Credits**

Employees with less than \$600 and no credits for twelve (12) consecutive months shall forfeit the residual amount and thereafter must establish eligibility as a new Employee.

## **New Employee Participants**

First-time participants must have accumulated an initial reserve of \$1,200 (2 months) before the monthly deduction for coverage can be made.

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

## **Eligibility Example**

To become covered initially, you must accumulate \$1,200 from one or more participating employers.

## **Qualifying Months and Coverage Months**

If, after initially becoming covered, you have \$600 on the last day of any of the qualifying months, you will be eligible for coverage in the corresponding months as shown in the chart below.

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<b>Qualifying Month</b>	<b>Coverage Month</b>	<b>Qualifying Month</b>	<b>Coverage Month</b>
May.....	July	November .....	January
June .....	August	December .....	February
July .....	September	January .....	March
August .....	October	February .....	April
September.....	November	March .....	May
October.....	December	April .....	June

On the first day of the calendar month preceding the coverage month, you shall have \$600 deducted from your reserve bank accumulation for one (1) month of coverage.

**Eligibility Based on Reciprocal Contributions**

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

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

**Category 2-Non-Bargaining Unit Participants**

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

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

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

1. Contributing employers under a Collective Bargaining Agreement with I.B.E.W. Local 332 and who are National Electrical Contractors Association (NECA) members permanently located in Santa Clara Valley may elect to cover their Employees not covered by the Collective Bargaining Agreement, but must cover all such Employees if there are less than 5 Employees in this Category. Employers with more than 5 Employees must cover 80% in this Category. For the purposes of this section, "Employee" does not include the spouse of an owner, unless the spouse is performing bargaining unit work.
2. Employers electing to cover Category (2) Employees must cover newly hired Category (2) Employees the first of the month following completion of 90 days of continuous full-time employment by paying the applicable monthly contribution for such coverage in advance. "Full time" means at least 80 hours per month or equivalent pay period.
3. Contributing employers not electing to cover their Category (2) Employees may only apply on each successive anniversary date of the Plan, which is January 1 of each year. All applications and payments must be in the Plan Administrator's Office by December 15th and, thereafter, the monthly charge for this group must be paid in advance each month at the Plan Administrator's Office. Acceptance of Category (2) payments is subject to Trustee audit in compliance with the foregoing.

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4. Non-Bargaining Unit Employees do not have a reserve bank accumulation but are eligible for all benefits under the Active Plan except the Short Term Disability Benefit. The Retiree Plan is also available to eligible retired Non-Bargaining Unit Employees. Non-Bargaining Unit Employees are not eligible for the Pre-Funded Early Retiree Plan.
5. The Trustees shall establish the monthly payment required for Category (2) participants from time to time. The amount of this monthly payment may be obtained by contacting the Plan Administrator's Office.
6. Employers electing to cover their Non-Bargaining Unit Employees must sign a written subscription agreement acknowledging the above rules and agreeing to be bound by the terms of the Trust Agreement for the I.B.E.W. Local 332 Health & Welfare Plan, and specifically to comply with Trust rules concerning compliance with payroll audits and assessment of liquidated damages and other costs if payments are not received on time.

### **Termination of Coverage**

Coverage for yourself and your Dependents will terminate:

1. On the last day of any month in which you fail to maintain the minimum reserve; or
2. On the last day of any month in which you fail to maintain the minimum reserve because your employer failed to pay the required contributions; or
3. On the last day of the calendar month in which you enter military service.

The coverage for a Dependent will terminate when the Dependent ceases to be an eligible Dependent.

# SELF-PAYMENT

## **COBRA CONTINUATION COVERAGE RIGHTS**

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

### **Introduction**

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

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

### **What is COBRA Continuation Coverage?**

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

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

1. Your hours of employment are reduced; or
2. Your employment ends for any reason.

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

1. Your spouse dies;
2. Your spouse’s hours of employment are reduced;
3. Your spouse’s employment ends for any reason;
4. Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse. If an Employee cancels coverage for his or her spouse in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse provides written notice to the Plan Administrator within sixty (60) days after the divorce or legal separation and can establish that the Employee canceled the coverage earlier in anticipation

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of the divorce or legal separation, then COBRA continuation coverage may be available for the period after the divorce or legal separation.

Your Dependent children will become qualified beneficiaries if they will lose coverage under this Plan or an insured plan (PacifiCare, Health Net or Kaiser) because any of the following qualifying events happens:

1. The parent-Employee dies;
2. The parent-Employee's hours of employment are reduced;
3. The parent-Employee's employment ends for any reason;
4. The parent-Employee becomes entitled to Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child is no longer eligible for coverage because he or she no longer qualifies as a "Dependent child."

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

### **Notices and Elections of COBRA Continuation Coverage**

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

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

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

I.B.E.W. Local 332  
Health and Welfare Plan  
c/o United Administrative Services  
1120 S. Bascom Avenue  
San Jose, CA 95128-3590

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

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

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

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

### **Benefits Available Under COBRA Continuation Coverage**

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

### **How Long COBRA Continuation Coverage Lasts**

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

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

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

### ***Disability extension of 18-month period of continuation coverage.***

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

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

If your family experiences another qualifying event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second qualifying event is timely given to the Plan Administrator. This extension may be available to the spouse and any Dependent children receiving COBRA continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child no longer qualifies as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under this Plan or an insured plan (PacifiCare, Health Net or Kaiser) had the first qualifying event not occurred. In all these cases, the spouse or Dependent child must make sure that the Plan Administrator is notified in writing of the second qualifying event within sixty (60) days of the second qualifying event. The spouse or Dependent child must follow the procedures specified in the box above, entitled "Notice Procedures." Your written notice must state the second qualifying event and the date it happened. If the second qualifying event is a divorce, your notice must include a copy of the divorce decree. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required sixty (60) day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.

### **How Much Does Continuation Coverage Cost?**

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

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

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

#### ***First Payment for COBRA continuation coverage.***

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

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

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

I.B.E.W. Local 332  
Health and Welfare Plan  
c/o United Administrative Services  
1120 S. Bascom Avenue  
San Jose, CA 95128-3590

#### ***Monthly payments for COBRA continuation coverage.***

After you make your first payment for COBRA continuation coverage, you will be required to pay for COBRA continuation coverage for each subsequent month of coverage. These monthly payments are due by the first day of the month. If you make a monthly payment on or before the first day of the month, your coverage under the Plan will

## SELF-PAYMENT

continue for that coverage period without any break. **The Plan will not send periodic notices of payment due for these coverage periods.**

Monthly payments for continuation coverage should be sent to:

I.B.E.W. Local 332  
Health and Welfare Plan  
c/o United Administrative Services  
1120 S. Bascom Avenue  
San Jose, CA 95128-3590

### ***Grace periods for monthly payments.***

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

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

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

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

1. The premium is not paid on time.
2. After electing COBRA continuation coverage, you, your spouse or Dependent child becomes enrolled in Medicare.
3. After electing COBRA continuation coverage, you, your spouse or Dependent child becomes covered under another group health plan (as an Employee or Dependent) that does not impose any pre-existing condition exclusion for a pre-existing condition. If the new group health plan has exclusions or limitations for pre-existing conditions, your COBRA continuation coverage will end after the exclusion or limitation period no longer applies. For example, after a six month waiting period, or under the federal law that requires portability of health care coverage (the Health Insurance Portability and Accountability Act of 1996), the pre-existing condition clause expires.
4. The I.B.E.W. Local 332 Health and Welfare Plan no longer provides group health coverage to any of its participants.
5. Your last employer no longer participates in the I.B.E.W. Local 332 Health and Welfare Plan and establishes one or more group health plans that covers a significant number of Employees who were formerly covered under the I.B.E.W. Local 332 Health and Welfare Plan or your last employer begins contributing to another multiemployer group health plan. In such a case, the new employer plan or multiemployer group health plan must assume the I.B.E.W. Local 332 Health and Welfare Plan's COBRA continuation coverage obligation for you, your spouse and Dependent children.

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

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

## SELF-PAYMENT

### **Transfer Rights**

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

### **More Information About Individuals Who May Be Qualified Beneficiaries**

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

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

#### ***Alternate recipients under Qualified Medical Child Support Orders.***

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

### **For More Information About COBRA Continuation Coverage**

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

### **Keep the Plan Administrator Informed of Address Changes**

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

United Administrative Services  
1120 S. Bascom Avenue  
San Jose, CA 95128-3590  
Phone: (408) 288-4400

### **Self-Payment and Free Coverage for Certain Disabled Employees**

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

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

## SELF-PAYMENT

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

### **Death**

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

### **Certificate of Former Coverage**

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

### **Military Service**

If your eligibility terminates because of entry into the military service, you may continue eligibility through self-payments for up to eighteen (18) months. Upon release from active service your eligibility may be reinstated in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. If you are on military leave for less than thirty-one (31) days, your employer is required to pay for your medical coverage.

### **Extended Coverage Under Family and Medical Leave Act**

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

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

1. Inpatient treatment;
2. Absence from work or school for three or more days with continuing treatment by a health care provider;
3. Continuing treatment by a health care provider for a condition that is incurable or serious enough to result in three (3) or more days of incapacity; or
4. Prenatal care.

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

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

## SUMMARY OF BENEFITS

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

### **ACTIVE EMPLOYEES ONLY**

Group Term Life Insurance (24-Hour Coverage) .....	\$22,000
Accidental Death & Dismemberment (24-Hour Coverage) .....	\$22,000
Additional Group Term Life Insurance (24-Hour Coverage) .....	\$28,000

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

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

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

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

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

Hospital-Medical-Surgical Expenses	80% of such Usual, Customary and Reasonable Charges each calendar year in excess of the \$100 deductible amount for each eligible person.
Private Room Limit	The average semi-private room charge made in the hospital where the eligible person is confined.
Blue Cross PPO Contract Hospitals	For services rendered in a PPO Contract Hospital, the Plan will pay 90% instead of 80% of the first \$2,500 of covered expenses each calendar year and 100% thereafter for the remainder of such calendar year. The \$100 deductible will also be waived. A list of Contract Hospitals is provided to you automatically, free of charge, as a separate document.
	The \$2,500 stop-loss threshold does not apply to services rendered by a non-PPO hospital provider. Therefore, the Plan will pay 80% of all Usual, Customary and Reasonable Charges each calendar year in excess of the \$100 deductible for services rendered by a non-PPO hospital provider even for expenses that exceed \$2,500.
Maximum Lifetime Benefit	\$2 million dollars for each eligible person.

**SUMMARY OF BENEFITS**

Maximum Lifetime Benefit for Chemical Dependency	\$25,000.
Deductible Amount	\$100 for all accidents and sickness applied once each calendar year for each eligible person. Maximum per family is \$300.
Supplemental Accident Benefit	\$500.
Convalescent Care	One-half of the average semi-private room allowance for 120 days in a convalescent period.
Mental Health Benefits Outpatient Services	80% of covered charges in excess of the \$100 deductible, up to a maximum of 16 visits in a 12-month period, except for emergency services, which require prior authorization by Blue Cross. Without prior authorization, benefits will not be paid.
Mental Health Benefits Inpatient Services	Covered up to a maximum of 45 days in a 12-month period, if approved by Blue Cross. Regular plan benefits are payable for services at contracting facilities, except for emergency services at non-contracting facilities, which are limited to 50% of normal benefits. Without prior authorization, benefits will not be paid.
Mental Health Benefits Residential Care Confinements	80% of covered charges up to a maximum of 270 days in a 12-month period at a pre-approved inpatient residential care facility for eligible Dependent children with an AXIS I diagnosis (as defined in the Diagnostic and Statistical Manual of Mental Disorders). Without prior authorization from Blue Cross benefits will not be paid.

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

Instead of the Self-Funded benefits described above, you may elect medical coverage through Kaiser, PacifiCare or Health Net. Kaiser, PacifiCare and Health Net benefits are described in detail by Kaiser, PacifiCare and Health Net brochures, which are available to you, upon request, from the Plan Administrator at no additional cost. Below is a summary of the benefits provided by Kaiser, Health Net and PacifiCare.

**ACTIVE AND CATEGORY 2 EMPLOYEES AND DEPENDENTS  
AND NON-MEDICARE ELIGIBLE RETIREES  
KAISER HMO PLAN**

Services	You Pay
<b>Annual Copayment Limit</b>	
For each member	\$1,500
For each Family Unit	\$3,000
<b>Outpatient Care</b>	
Allergy injection visits	No charge
Eye exams to provide a prescription for eyeglasses	\$10 per visit
Hearing exams	\$10 per visit
Immunizations	No charge
Outpatient surgery	\$10 per procedure
Physical, occupational, and speech therapy visits	\$10 per visit
Primary and specialty care visits for internal medicine, family practice, pediatrics, and gynecology (includes routine and urgent care appointments)	\$10 per visit
Scheduled prenatal care and first postpartum visit	\$5 per visit
Well-child preventive care visits (23 months or younger)	\$5 per visit
X-rays and lab tests	No charge
<b>Hospital Inpatient Care</b>	
Hospital room and board, surgery, anesthesia, X-rays, lab tests, and medications	No charge

**SUMMARY OF BENEFITS**

Skilled Nursing Facility (up to 100 days per benefit period)	No charge
<b>Prescription Drugs</b>	
Covered items in accord with our formulary when obtained at Plan pharmacies:	
Generic	\$10 up to a 100-day supply (or 3 cycles for oral contraceptives)
Brand name or compounded drugs	\$20 up to a 100-day supply (or 3 cycles for oral contraceptives)
Drugs related to the treatment of sexual dysfunction disorders (episodic drugs are limited to 27 doses in any 100-day period)	50% Coinsurance up to a 100-day supply
<b>Family Planning</b>	
Hospital inpatient care	No charge
Office visits	\$10 per visit
Outpatient lab tests, X-rays, and special procedures	No charge
Outpatient surgery	\$10 per procedure
<b>Mental Health Services</b>	
Inpatient psychiatric care (up to 45 days per calendar year)	No charge
Outpatient visits:	
Up to a total of 20 individual and/or group therapy visits per calendar year	
Individual therapy visits	\$10 per visit
Group therapy visits	\$5 per visit
Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year	\$5 per visit
<i>Note: Visit and day limits do not apply to severe mental illnesses and serious emotional disturbances of children.</i>	
<b>Chemical Dependency Services</b>	
Inpatient detoxification	No charge
Outpatient group therapy visits	\$5 per visit
Outpatient individual therapy visits	\$10 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	\$100 per admission
<b>Other Services</b>	
Ambulance Services	\$50 per trip
Durable medical equipment in accord with our formulary	No charge
External prosthetic and orthotic devices	No charge
Health education for specific conditions:	
Individual visits	\$10 per visit
Group visits	No charge
Home health care	No charge
Hospice care	No charge
<b>Emergency Care</b>	
Emergency Department visits	\$50 per visit (waived if admitted directly to the hospital)

***The above is only a summary of the benefits available under the Kaiser HMO. You may request a more detailed explanation of the benefits provided under the Kaiser HMO, including definitions of the terms used in the above summary, at no cost from the Plan Administrator.***

SUMMARY OF BENEFITS

**MEDICARE ELIGIBLE RETIREES  
KAISER HMO PLAN**

<b>Services</b>	<b>You Pay</b>
<b>Annual Copayment Limit</b>	
For each member	\$1,500
For each Family Unit	\$3,000
<b>Outpatient Care</b>	
Allergy injection visits	No charge
Eye exams to provide a prescription for eyeglasses	\$10 per visit
Hearing exams	\$10 per visit
Immunizations	No charge
Manual manipulation of the spine	\$10 per visit
Outpatient surgery	\$10 per procedure
Physical, occupational, and speech therapy visits	\$10 per visit
Primary and specialty care visits for internal medicine, family practice, pediatrics, and gynecology (includes routine and urgent care appointments)	\$10 per visit
Scheduled prenatal care and first postpartum visit	\$10 per visit
Well-child preventive care visits (23 months or younger)	\$10 per visit
X-rays, annual mammograms, and lab tests	No charge
<b>Hospital Inpatient Care</b>	
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	No charge
<b>Prescription Drugs</b>	
Covered items in accord with our formulary when obtained at Plan pharmacies:	
Generic	\$10 up to a 100-day supply
Brand name or compounded drugs	\$20 up to a 100-day supply
Drugs related to the treatment of sexual dysfunction disorders (episodic drugs are limited to 27 doses in any 100-day period)	50% Coinsurance up to a 100-day supply
<b>Mental Health Services</b>	
Inpatient psychiatric care: first 190 days per lifetime as covered by Medicare. Thereafter, up to 45 days per calendar year	No charge
Outpatient visits:	
Individual and group therapy visits	
Individual therapy visits	\$10 per visit
Group therapy visits	\$5 per visit
Note: Visit and day limits do not apply to severe mental illnesses and serious emotional disturbances of children as described in the <i>Evidence of Coverage</i> .	
<b>Chemical Dependency Services</b>	
Inpatient detoxification	No charge
Outpatient group therapy visits	\$5 per visit
Outpatient individual therapy visits	\$10 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	\$100 per admission
<b>Other Services</b>	
Ambulance Services	\$50 per trip
Durable medical equipment in accord with our formulary	No charge
External prosthetic and orthotic devices	No charge
Eyewear purchased from Plan optical sales offices every 24 months	\$150 allowance*
Health education for specific conditions:	
Individual visits	\$10 per visit

**SUMMARY OF BENEFITS**

Group visits	No charge
Home health care (part-time, intermittent)	No charge
Skilled nursing facility care (up to 100 days per benefit period)	No charge
<b>Emergency Services</b>	
Emergency Department visits	\$50 per visit (waived if admitted to the hospital within 24 hours for the same condition)

\* Your price will be reduced by the allowance indicated. If the price of the item(s) you select exceeds the allowance, you will pay the difference.

**The above is only a summary of the benefits available under the Kaiser HMO. You may request a more detailed explanation of the benefits provided under the Kaiser HMO, including definitions of the terms used in the above summary, at no cost from the Plan Administrator.**

**ACTIVE AND CATEGORY 2 EMPLOYEES AND DEPENDENTS  
AND NON-MEDICARE ELIGIBLE AND MEDICARE ELIGIBLE RETIREES  
HEALTH NET HMO PLAN**

Services	You Pay
<b>Annual Copayment Limit</b>	
For each member	\$1,500
For two-party	\$3,000
For each family (3 or more members)	\$4,500
<b>Outpatient Care</b>	
Administration of anesthetics	No charge
Allergy injection services (serum not included)	\$10 Copayment
Allergy serum	Not covered
Allergy testing	No charge
All other injections	\$10 Copayment
Annual routine physical examinations	Not covered
Chemotherapy (professional services only)	No charge
Circumcision of newborn	No charge
Complications of pregnancy including medically necessary abortions	No charge
Dental services (when medically necessary to properly monitor, control, or treat a severe medical condition when excluded dental services are being performed)	No charge
Elective abortions	\$150 Copayment
Genetic testing of fetus	No charge
Immunizations for foreign travel/occupational purposes	20% Copayment
Injections related to infertility services	50% Copayment
Normal delivery, Cesarean section (includes newborn inpatient care provided by a member physician)	No charge
Nuclear medicine (professional services only)	No charge
Other immunizations (except foreign travel/occupational - see above)	No charge
Periodic health evaluations (Includes routine, preventive care, and well-baby care)	\$10 Copayment
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders)	No charge
Physician visit to member's home (at discretion of physician)	\$20 Copayment
Postnatal office visit	No charge
Prenatal office visit	\$10 Copayment/No charge <sup>1</sup>
Rehabilitation therapy (inpatient/outpatient physical, speech, occupational and respiratory therapy; provided as long as significant improvement is expected)	\$10 Copayment
Renal dialysis (professional services only)	No charge
Specialist consultations (Includes OB/GYN self-referral)	\$10 Copayment

## SUMMARY OF BENEFITS

Surgeon/assistant surgeon in hospital or PPG	No charge
Vision and hearing examinations	\$10 Copayment
Visit to a physician, physician assistant or nurse practitioner at a Preferred Provider Group (PPG)	\$10 Copayment
X-ray and laboratory procedures	No charge
<b>Hospital Inpatient Care</b>	
Unlimited days of hospital care in a semi-private room or ICU with ancillary services (excluding care for mental disorders)	No charge
Maternity care (Includes routine nursery charges)	No charge
Organ and bone marrow transplants (non-experimental and noninvestigative Professional services only)	No charge
Outpatient services	No charge
Skilled Nursing Facility (limited to 100 days a calendar year)	No charge
<b>Family Planning</b>	
Contraceptive devices	Not covered
Infertility services (including professional services, inpatient and outpatient care, treatment by injection and prescription drugs, if applicable)	50% Copayment
Reversal of sterilization	Not covered
Sterilization of females	\$150 Copayment
Sterilization of males	\$50 Copayment
<b>Mental Health and Chemical Dependency Services</b>	
Administered by Managed Health Network (MHN). Refer to the MHN telephone number on the back of your Health Net ID card.	
<b>Other Services</b>	
Air ambulance	No charge
Blood, blood plasma, blood factors and blood derivatives	No charge
Durable medical equipment	No charge
Diabetic supplies (refer to the Introduction section for additional information)	No charge
Ground ambulance	No charge
Hearing aids	Not covered
Home health visit (the copayment starts the 31st calendar day after the first visit)	\$10 Copayment
Hospice care	No charge
Medical social services	No charge
Patient education	No charge
Prosthesis (replacing body parts)	No charge
<b>Emergency Care/Urgently Needed Care <sup>2</sup></b>	
Use of emergency room (facility and professional services) <sup>3</sup>	\$50 Copayment
Use of urgent care center (facility and professional services) <sup>3</sup>	\$50 Copayment

<sup>1</sup> For each pregnancy, the initial prenatal visit requires a \$10 copayment. No copayment is required for subsequent prenatal office visits.

<sup>2</sup> Non-emergency care (including urgently needed care) received **within** the PPG service area must be performed or authorized by the member's PPG in order for services to be covered. When urgently needed care is provided **outside** the PPG service area, authorization is not mandatory in order for services to be covered. When services are provided that meet the criteria for emergency care, whether **within or outside** the PPG service area, the services are covered, even if the member never contacted the PPG.

<sup>3</sup> The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room or urgent care center.

***The above is only a summary of the benefits available under the Health Net HMO. You may request a more detailed explanation of the benefits provided under the Health Net HMO, including definitions of the terms used in the above summary, at no cost from the Plan Administrator.***

SUMMARY OF BENEFITS

**ACTIVE AND CATEGORY 2 EMPLOYEES AND DEPENDENTS  
AND NON-MEDICARE ELIGIBLE RETIREES  
PACIFICARE HMO PLAN**

<b>Services</b>	<b>You pay</b>
<b>Annual Copayment Maximum</b> <sup>1</sup>	
3 individual maximum per family	\$1,000/individual
<b>Outpatient Care</b>	
Alcohol, Drug or Other Substance Abuse - Detoxification	No charge
Allergy Testing/Treatment (serum is not covered unless an allergy serum rider was purchased by your employer)	\$10 Copayment
Cancer Clinical Trials <sup>2,3</sup>	You pay balance, if any, after payment at contracting rate
Dental Treatment Anesthesia (additional charges for outpatient and inpatient surgery may apply)	\$10 Copayment
Hearing Screening	\$10 Copayment
Hemodialysis (Physician office visit Copayment may apply)	\$10 per treatment
Immunizations (for children under two years of age, refer to Well-Baby Care)	No charge
Infertility Services	50% Copayment <sup>6</sup>
Laboratory and Radiology (when available through and authorized by the Member's Participating Medical Group)	No charge
Maternity Care, Tests and Procedures	No charge
Office Visits	\$10 Copayment
Oral Surgery Services	No charge
Outpatient Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (including physical, occupational and speech therapy)	\$10 Copayment
Outpatient Surgery	No charge
Periodic Health Evaluations (Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group to determine your health status; for children under two years of age refer to Well-Baby Care.)	\$10 Copayment
Physician Care (for children under two years of age, refer to Well-Baby Care)	No charge
Vision Refractions	\$10 Copayment
Vision Screening	\$10 Copayment
Well-Baby Care (Preventative health service, including immunizations recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group for children under two years of age. The applicable office visit Copayment applies to infants that are ill at time of services.)	No charge
Well-Woman Care (Includes Pap smear by your Primary Care Physician or an OB/GYN in your Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force.)	\$10 Copayment
<b>Hospital Inpatient Care</b>	
Alcohol, Drug or Other Substance Abuse - Detoxification	No charge
Bone Marrow Transplants (donor searches limited to \$15,000 per procedure)	No charge
Cancer Clinical Trials <sup>2,3</sup>	You pay balance, if any, after payment at contracting rate
Hospice Care (autologous (self-donated) blood up to \$120.00 per unit)	No charge
Hospitalization	No charge
Mastectomy/Breast Reconstruction (after mastectomy and complications from mastectomy)	No charge
Maternity Care	No charge

**SUMMARY OF BENEFITS**

Newborn Care <sup>4</sup>	No charge
Physician Care	No charge
Reconstructive Surgery	No charge
Rehabilitation Care (including physical, occupational and speech therapy)	No charge
Skilled Nursing Care (up to one hundred (100) consecutive calendar days from the first treatment per disability)	No charge
<b>Prescription Drugs</b>	
Retail Pharmacy (per Prescription Unit or up to 30 days)	
Generic	\$10
Brand Name	\$20
Mail-Service Pharmacy (up to 3 Prescription Units or up to 90 days)	
Generic	\$20
Brand Name	\$40
<b>Family Planning</b>	
Vasectomy	\$50 Copayment
Tubal ligation <sup>5</sup>	\$100 Copayment
Insertion/removal of Intra-Uterine Device (IUD)	\$10 Copayment
Intra-Uterine Device (IUD)	50% Copayment <sup>6</sup>
Removal of Norplant	\$10 Copayment
Depo-Provera injection	\$10 Copayment
Depo-Provera medication (Limited to one Depo-Provera injection every 90 days)	\$35 Copayment
Voluntary interruption of pregnancy (medical/medication and surgical)	
--1st trimester	\$75 Copayment
--2nd trimester (12-20 weeks)	\$150 Copayment
--After 20 weeks	Not covered unless mother's life is in jeopardy or fetus not viable
<b>Mental Health Services <sup>7</sup></b>	
Mental Health Services (As required by state law, coverage includes treatment for Severe Mental Illnesses (SMI) of adults and children and for children the treatment of Serious Emotional Disturbance of Children (SED).)	\$10 Copayment per visit
Inpatient, Residential and Day Treatment. Up to 30 days per Calendar Year based on the following levels of care: Inpatient Treatment = 1 day Residential Treatment = 70% of 1 day Day Treatment = 60% of 1 day	No charge
Outpatient Treatment (Up to 30 visits per Calendar Year)	\$10 Copayment
Emergency	\$50 Copayment waived if admitted as inpatient
Urgently Needed Services (Medically Necessary services required outside the geographic area served by your Participating Medical Group.)	\$50 Copayment waived if admitted as inpatient
<b>Severe Mental Illness Benefit <sup>7, 8, 9</sup></b>	
Inpatient, Residential and Day Treatment (Unlimited days)	No charge
Outpatient Treatment (Unlimited visits)	\$10 Copayment
Emergency	\$50 Copayment waived if admitted as inpatient
Urgently Needed Services (Medically Necessary services required outside the geographic area served by your Participating Medical Group.)	\$50 Copayment waived if admitted as inpatient
<b>Chemical Dependency Services <sup>7</sup></b>	
Inpatient and Outpatient Treatment (Maximum Annual Benefit for detoxification and all	No charge

## SUMMARY OF BENEFITS

levels of care limited to \$25,000 per Calendar Year; \$35,000 Lifetime Maximum Benefit)	
Emergency	\$50 Copayment waived if admitted as inpatient
Urgently Needed Services (Medically Necessary services required outside the geographic area served by your Participating Medical Group.)	\$50 Copayment waived if admitted as inpatient
<b>Other Services</b>	
Ambulance	No charge
Chiropractic Care	\$10 Copayment per visit (30 visit annual maximum)
Cochlear Implants (Outpatient surgery or inpatient hospitalization and outpatient rehabilitation therapy Copayments may apply)	No charge
Crisis Intervention (up to twenty (20) visits for Crisis Intervention per calendar year)	\$35 Copayment
Durable Medical Equipment, Corrective Appliances and Prosthetics	No charge
Health Education Services	No charge
Home Health Care	No charge
Hospice Care (prognosis of life expectancy of one year or less)	No charge
<b>Emergency Care/Urgently Needed Care</b>	
Emergency Services	\$50 Copayment waived if admitted as inpatient
Urgently Needed Services (Medically Necessary services required outside the geographic area served by your Participating Medical Group.)	\$50 Copayment waived if admitted as inpatient

<sup>1</sup> Annual Copayment Maximum does not include Copayments for pharmacy and supplemental benefits.

<sup>2</sup> Cancer Trial. Services require preauthorization by PacifiCare.

<sup>3</sup> If you participate in a clinical trial provided by a Non-Participating Provider that does not agree to perform these services at the rate PacifiCare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Provider's billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayments, Coinsurance or Deductibles.

<sup>4</sup> The newborn care Copayment does not apply when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the *Combined Evidence of Coverage and Disclosure Form* for more details.

<sup>5</sup> Copayment applies regardless of whether this benefit is performed on an inpatient or outpatient basis. If performed on an inpatient basis, additional inpatient Copayment, if any, will apply.

<sup>6</sup> Percentage Copayment amounts are based upon PacifiCare's contracted rate

<sup>7</sup> Preauthorization is required for all Mental Health Services, Chemical Dependency Services and Severe Mental Illness (SMI) Benefits. You do not need to go through your Primary Care Physician, but you must obtain prior authorization through PacifiCare Behavioral Health of California (PBHC), an affiliate of PacifiCare that specializes in mental health and chemical dependency benefits. PBHC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

<sup>8</sup> Severe Mental Illness diagnoses include: Anorexia Nervosa, Bipolar Disorder, Bulimia Nervosa, Major Depressive Disorder, Obsessive-Compulsive Disorder, Panic Disorder, Pervasive Developmental Disorder or Autism, Schizoaffective Disorder, and Schizophrenia. In addition, the Severe Mental Illness Benefit includes coverage of Serious Emotional Disturbance of Children (SED).

<sup>9</sup> The Lifetime Dollar Maximum for Severe Mental Illness will be applied to the Medical Plan Lifetime Dollar Maximum Benefit, if applicable.

Except in the case of a Medically Necessary Emergency or an Urgently Needed Service (outside the geographic area served by your Participating Medical Group), each of the above-noted benefits is covered when authorized by your Participating Medical Group or PacifiCare. A utilization review committee may review the request for services.

***The above is only a summary of the benefits available under the PacifiCare HMO. You may request a more detailed explanation of the benefits available under the PacifiCare HMO, including definitions of the terms used in the above summary, at no cost from the Plan Administrator.***

SUMMARY OF BENEFITS

**MEDICARE ELIGIBLE RETIREES  
PACIFICARE SECURE HORIZONS MEDICARE+CHOICE HMO PLAN**

Services	You pay
<b>Outpatient Care</b>	
Annual Physical Examination (includes pap smears)	
Primary Care Physician	\$10 copayment per office visit
Specialist	\$20 copayment per office visit
Covered injectables	No charge
Examination for eyeglasses (refraction)	
Primary care physician	\$10 copayment
Specialist	\$20 copayment
Immunizations (includes flu shots, pneumococcal vaccine, Hepatitis B injections and all other Medicare approved immunizations)	No charge
Insulin	Brand copayment per prescription unit
Medicare-covered immunosuppressive Drugs	No charge
Medicare-covered Oral Chemotherapy Drugs	No charge
<b>Outpatient Surgical Services</b>	
Certified Ambulatory Surgical Center	\$125 copayment
Outpatient Hospital Facility	\$125 copayment
Physician Services/ Basic Health Services (includes consultation, diagnosis and treatment)	
Primary Care Physician	\$10 copayment per office visit
Specialist	\$20 copayment per office visit
Radiation Therapy (routine or complex)	No charge
Renal Dialysis	Covered in full
Routine Hearing Examination	
Primary care physician	\$10 copayment
Specialist	\$20 copayment
<b>Hospital Inpatient Care</b>	
Hospitalization	\$250 copayment per admission <sup>1</sup>
Skilled Nursing Facility (Medicare certified)	
Days 1-20	No charge
Days 21-100 (limit 100 days per benefit period <sup>3</sup> as defined by Medicare)	\$50 per day
<b>Prescription Drugs</b>	
Contracting Retail Pharmacy (per prescription for 30-day supply of drugs prescribed by a Secure Horizons Medicare+Choice Plan contracting physician) <sup>2</sup>	
Generic	\$10
Brand Name	\$20
Mail-Service Pharmacy (per prescription for 90-day supply) <sup>2</sup>	
Generic	\$20
Brand Name	\$40
<b>Mental Health and Chemical Dependency Services</b>	
Outpatient Mental Health Care/Outpatient Substance Abuse Treatment	\$20 copayment
Inpatient Psychiatric Care/Inpatient Substance Abuse Treatment	\$250 copayment per admission up to 190 days lifetime maximum in a psychiatric hospital

**SUMMARY OF BENEFITS**

<b>Other Services</b>	
Ambulance (medically necessary ambulance transport)	\$50 copayment
Chiropractic Services (Medicare Benefit ONLY) Primary care physician Specialist	\$10 copayment \$20 copayment
<b>Emergency Care/Urgently Needed Care</b>	
Emergency Services (You may go to any emergency room if you reasonably believe you need emergency care.)	\$50 Copayment waived if admitted as inpatient within 24 hours for same condition
Non-network/Out of Area Urgent Care	\$25 Copayment

<sup>1</sup> Inpatient Hospital Copayments are charged on a per admission basis. Original Medicare hospital benefit periods do not apply. For Inpatient Hospital, you are covered for an unlimited number of days as long as the hospital stay is medically necessary and authorized by PacifiCare or contracting providers. When you are admitted to an Inpatient Hospital and then are subsequently transferred to another Inpatient Hospital, you pay the copayment charged for the first hospital admission. You do not pay a copayment for the second hospital admission; the copayment is waived.

<sup>2</sup> Unlimited prescription drug benefit and formulary apply.

<sup>3</sup> A benefit period begins the day you go to a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't received hospital or skilled care (in a SNF) for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

***The above is only a summary of the benefits available under the PacifiCare Secure Horizons Medicare+Choice HMO. You may request a more detailed explanation of the benefits available under the PacifiCare Secure Horizons Medicare+Choice HMO, including definitions of the terms used in the above summary, at no cost from the Plan Administrator.***

**DENTAL BENEFITS FOR ACTIVE AND CATEGORY 2 EMPLOYEES AND DEPENDENTS**

100% of reasonable and customary Class I Diagnostic/Preventative Services (1) (2) (3) listed in the Dental Section.

80% of reasonable and customary Class II Basic Services (1) through (10) listed in the Dental Section.

60% of reasonable and customary Class III Major Services (1) through (7) listed in the Dental Section.

60% of reasonable and customary Class IV Orthodontic Services.

Deductible Amount \$25 per person per year for Class II, III, and IV services.

Maximum Payment \$2,000 per calendar year for Class I, II and III services. \$2,000 per lifetime for Class IV services.

**HEARING CARE BENEFIT**

See Hearing Care Benefits Section.

**VISION CARE BENEFITS**

See Vision Care Benefits Section.

# LIFE INSURANCE

## **TERM LIFE INSURANCE (For Active and Category 2 Employees)**

Those Employees who have selected either the regular self-funded plan, Kaiser Foundation Health Plan, Health Net Plan, or PacifiCare Plan, will receive a Group Term Life Insurance benefit in the amount of \$22,000.

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

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

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

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

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

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

Payment may be received:

1. in a lump sum;
2. in a series of monthly installments; or
3. partly in a lump sum and the balance in a series of monthly installments.

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

### **LIFE INSURANCE CONVERSION**

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

#### **Definition**

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

## LIFE INSURANCE

### **Death During Life Conversion Period**

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

### **The Personal Policy**

1. Must be applied for and the first premium paid to the Insurance Company during the *life conversion period*;
2. Shall be in an amount chosen by you which is equal to or less than the amount of Life Insurance for which you were insured under the Group Insurance Policy;
3. Shall contain no disability or accidental death benefits;
4. Shall be in a form, other than term insurance, which the Insurance Company then customarily issues to a person of your age and subject to any minimum face amount requirements;
5. Shall require payment of premiums at the Insurance Company's current rates for: (a) the type and amount of the policy; (b) the class of risk which applies to you; and (c) your attained age on the effective date of the personal policy;
6. Shall be effective on its date of issue; such date shall not be earlier than the next day after the *life conversion period* ends.

### **EXTENSION OF YOUR LIFE INSURANCE WHILE TOTALLY DISABLED**

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

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

### **Amount of Insurance During the Extension Period**

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

### **Proof of Disability**

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

### **Date Extension Commences**

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

### **Date Extension Ceases**

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

# ACCIDENTAL DEATH & DISMEMBERMENT

## **ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT (For Active and Category 2 Employees)**

The Plan pays an accidental death, including dismemberment and loss of sight, benefit.

1. Accidental Death Benefit Full Amount \$22,000

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

- a. the loss (i) results from an accidental bodily injury which occurred while the individual was covered, and (ii) was independent of all other causes;
- b. the accidental bodily injury is evidenced by a visible bruise or wound [except in the case of (i) internal injuries shown by autopsy, or (ii) drowning]; and
- c. the loss occurs no more than 90 days after the injury.

2. Exclusions

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

- a. self-destruction or attempted self-destruction or intentionally self-inflicted injury, while sane or insane; or
- b. insurrection, riot, or war; or
- c. the committing of, or the attempting to commit, an assault or felony; or
- d. disease or disorder of the body or mind; or
- e. medical or surgical treatment or diagnosis or preventive care; or
- f. ptomaines or bacterial infection (except only in pyogenic infection occurring at the same time as, and as a result of, a visible accidental wound); or
- g. the voluntary or involuntary: i) taking of drugs (except drugs taken as prescribed by a doctor) or poison; or ii) inhaling of gas.

3. Table of Losses

<u>In the Event of Loss of:</u>	<u>The Amount Payable Will Be:</u>
Life	The Full Amount
Both Hands or Both Feet	The Full Amount
Sight of Both Eyes	The Full Amount
One Hand and One Foot	The Full Amount
One Hand and Sight of One Eye	The Full Amount
One Foot and Sight of One Eye	The Full Amount
One Hand	One-Half The Full Amount
One Foot	One-Half The Full Amount
Sight of One Eye	One-Half The Full Amount
Thumb and Index Finger of Either Hand	One-Fourth The Full Amount

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

# SHORT-TERM DISABILITY BENEFIT

## **FOR ACTIVE EMPLOYEES ONLY**

### Accident and Sickness (Weekly Benefit)

1st thirteen weeks .....	\$100
2nd thirteen weeks .....	\$150

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

This protection is designed to partially replace an Employee's income during periods of temporary disability. The Plan provides for payment up to the maximum shown in the Summary of Benefits beginning on the 1st day of such disease or illness if hospital-confined. The compensation continues for a maximum period of 26 weeks for each disability.

The Employee need not be confined to his/her home, but he/she must be wholly and continuously disabled as to be prevented from performing each and every function pertaining to his/her employment and must be under the care of a legally qualified physician or surgeon.

All disability absences will be considered as having occurred during a single period of disability unless acceptable evidence is furnished that:

- (a) the causes of the latest disability absence cannot be connected with the cause of any of the prior disability absences and the latest disability absence occurs after return to active full-time work for at least one day; or
- (b) a connection with prior disability absences can be established but that, between the last of the previous disability absences which are connected and the latest one, you have returned to active full-time work for at least two consecutive weeks.

The disability absence must commence while Plan coverage is in force and while the Employee was working or signed on the out-of-work list and available for work for a contributing employer.

A terminated Employee, who is not signed on the out-of-work list or is making COBRA self-payments is not eligible for this benefit. Dependents are not eligible for this benefit.

Weekly payments for this short-term disability plan are paid directly from Trust Fund assets.

Claims received at the Plan Administrator's Office more than sixty (60) days after the inception of the Employee's disability absence will not be paid, unless the Employee provides satisfactory evidence that he/she has remained continuously disabled from the inception of the disability absence through the date the application is received.

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

# SELF-FUNDED MEDICAL BENEFITS

## FOR ACTIVE AND CATEGORY 2 EMPLOYEES AND DEPENDENTS

### HOSPITAL AND MEDICAL

**Deductible** ..... a cash deductible of \$100

(Out-of-pocket expense)-(Family Maximum \$300)

A maximum of three times the individual cash deductible, no more than \$100 of which may be satisfied by only one person, will be applied to the covered charges incurred by a family unit during any benefit period.

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

#### **PPO Contracted Hospitals**

If you use a Blue Cross Preferred Provider Organization (PPO) Contract Hospital your deductible is waived and the Plan will pay ninety percent (90%) (instead of eighty percent (80%)) of covered charges of the first \$2,500 (\$7,500 per family unit) of eligible expenses and will pay one hundred percent (100%) (instead of eighty percent (80%)) of covered charges for the remainder of the calendar year. A list of Contract Hospitals is provided to you automatically, free of charge, as a separate document. The ten percent (10%) coinsurance of covered charges will apply to the out-of-pocket expense maximum of \$500 for the individual and \$1,500 per family.

The \$2,500 stop-loss threshold does not apply to services rendered by a non-PPO hospital provider. Therefore, the Plan will pay 80% of all Usual, Customary and Reasonable Charges each calendar year in excess of the \$100 deductible for services rendered by a non-PPO hospital provider even for expenses that exceed \$2,500.

**Benefit Percentage** ..... **80%**

The self-funded medical plan pays eighty percent (80%) of covered charges incurred by covered individuals during a calendar year in excess of the \$100 individual deductible amount (\$300 maximum per family unit). The twenty percent (20%) coinsurance of covered charges will apply to the out-of-pocket expense maximum of \$500 for the individual and \$1,500 per family.

#### **Maximum Benefit**

The maximum lifetime benefit per individual is Two Million Dollars (\$2,000,000), except that substance abuse, alcoholism, chiropractic, acupuncture, and diabetes management training charges are not included in the out-of-pocket expense maximum. These items have separate maximums and allowances.

#### **Benefit Period**

A Benefit Period for an individual begins when the individual has incurred in a calendar year covered charges which exceed the deductible amount. Included will be covered charges incurred in October, November and December of the preceding calendar year for which no benefits were paid because such charges were applicable to the deductible amount.

A Benefit Period for an individual ends on the earliest of the following:

1. The last day of the calendar year in which it was established; or
2. The day coverage provided under this Plan ends; or
3. The day the maximum benefit is paid.

### UTILIZATION

## SELF-FUNDED MEDICAL BENEFITS

### REVIEW PROGRAM

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

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

1. **You are free to use any hospital or doctor when services are necessary. However, when you or your covered dependents receive services from a participating provider, the charges are less and your out-of-pocket co-payment is lower.**
2. Participating hospitals and physicians' offices agree to bill the health plan and not require payment by the patient at the time of service. Any billing for the patient's portion (if any) is after the Plan has paid and sent its Explanation of Benefits to the patient and to the hospital or physician.
3. For emergencies requiring immediate care, use the most readily available qualified help.
4. **Non-emergency hospital admissions should have pre-admission authorization whether the planned admission is at a participating or a non-participating hospital.** Please be sure that your physician's office remembers to telephone the review office at 1-800-274-7767. For emergency admissions, the review office should be notified within 24 hours.

#### **The Process Is Simple**

There are three simple steps to the medical inpatient program: Pre-Admission Review, Concurrent Review, and Discharge Planning.

#### **Pre-Admission Review**

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

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

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

#### **Emergency Admissions**

Emergency admissions do not require a Pre-Admission Review. However, Blue Cross must be notified of an emergency hospitalization the first business day following admission. This call may be made by the patient, a family member, the physician, or the hospital staff.

**Be certain everyone in your family knows that all hospital admissions under the self-funded plan need to be called into Blue Cross.** The physician and the hospital will be happy to help you *IF* they know you are covered by a review service.

## SELF-FUNDED MEDICAL BENEFITS

### **Concurrent Review**

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

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

### **Discharge Planning**

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

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

### **Appeals Process**

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

### **UTILIZATION REVIEW IT WORKS FOR YOU - WITH YOUR HELP!**

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

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

**Blue Cross PPO**

### **HEALTH CARE INFORMATION AND ASSISTANCE**

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

### **How It Works**

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

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

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

All calls are handled confidentially.

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

## SELF-FUNDED MEDICAL BENEFITS

### **Examples of Questions or Assistance**

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

### **COVERED CHARGES**

1. Semi-private room and board and routine nursing for confinement in a hospital.
2. Semi-private room and board and routine nursing for confinement in a skilled nursing facility (not to exceed the average semi-private room rate). Services must commence within 14 days after discharge from a stay of three (3) or more days in an acute care hospital.
3. Intensive Nursing Care for each day of confinement in a hospital as follows:
  - a. For those hospitals which make a separate charge for Intensive Nursing Care, the hospital's specific charge for Intensive Nursing Care is covered.
  - b. For those hospitals which make a combined charge for Room and Board and Intensive Nursing Care, that part of the combined charge that is in excess of the hospital's prevailing semi-private Room and Board rate will be the covered charge for Intensive Nursing Care.
4. Anesthetics and their administration.
5. Medical treatment given by or at the direction of a physician, if such treatment is within the scope of the provider.
6. Usual, Customary and Reasonable Charges of a physician or surgeon for the performance of an operation, the repair of a dislocation or fracture, and for medical services. Charges of an assistant surgeon are also covered.
7. Services of a Licensed Practical Nurse (L.P.N.) for private duty nursing services in a hospital.
8. Services of a licensed physiotherapist.
9. Charges by a doctor or speech therapist for rehabilitative speech therapy due to an illness (other than a functional nervous disorder), or due to surgery on account of an illness. If the speech therapy is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.
10. X-ray exams (other than dental), lab tests, and other diagnostic services.
11. X-ray and radiation therapy.
12. Charges for the repair of sound natural teeth (including their replacement) required as a result of, and within 24 months of, an accidental bodily injury that occurs while the person is covered under the Plan.
13. Transportation within the United States and Canada of the covered individual by professional ambulance service, railroad, or scheduled airline to, but not returning from a hospital or sanitarium.

## SELF-FUNDED MEDICAL BENEFITS

These charges will be covered only if the covered individual's illness cannot be adequately treated in the locale where the illness occurs.

### 14. Medical supplies as follows:

- a. Drugs which require a written prescription from a doctor and must be dispensed by a licensed pharmacist or doctor.
- b. Blood and other fluids to be injected into the circulatory system.
- c. Artificial limbs and eyes for loss of natural limbs and eyes which occurred while coverage is in force.
- d. Lens, each eye (contact or frames) immediately following and because of cataract surgery only.
- e. Casts, splints, trusses, braces, crutches, and surgical dressings.
- f. Purchase or rental of hospital-type equipment for kidney dialysis for your personal and exclusive use. The total purchase price considered will be on a monthly pro-rata basis during the first 24 months of ownership, but only so long as a dialysis treatment continues to be medically necessary. Also covered are all charges for supplies, materials and repairs necessary for the proper operation of such equipment and reasonable and necessary expenses for the training of a person to operate and maintain the equipment for your sole benefit. No benefits are paid on or after the day you are entitled to benefits under Medicare.
- g. Rental (not to exceed the purchase price) or purchase (if the cost is less than the rental for the period required) of durable medical equipment such as oxygen, a wheelchair, or hospital bed for medically necessary therapeutic treatment of a covered illness or non-industrial injury, which is:
  - (1) manufactured specifically for medical use, and of no further use when medical need ends;
  - (2) usable only by the patient;
  - (3) not primarily for the comfort or hygiene of the eligible individual, or solely to aid the caregiver;
  - (4) not for environmental control;
  - (5) not for exercise;
  - (6) approved as effective and usual and customary treatment of a condition as determined by the Fund; and
  - (7) not for prevention purposes.

### 15. Maternity Expenses and Well Baby Coverage:

Maternity expenses are covered the same as any other illness and cover only female Employees and dependent wives. Coverage must be in effect at the time of delivery. Hospital well baby nursery charges are covered only in contract hospitals and only during the mother's normal maternity stay.

The Plan will cover up to eight (8) visits for physical examinations and immunizations for your eligible Dependent child(ren) through the first 36 months of life. Routine immunizations are covered at one hundred percent (100%) and routine outpatient examinations or diagnostic testing is covered at eighty percent (80%) of actual charges.

There is no deductible for covered well baby/baby care expenses.

Effective January 1, 1998, group health plans and health insurance issuers offering group health coverage generally may not, under federal law, restrict available benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from

## SELF-FUNDED MEDICAL BENEFITS

discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of time in excess of 48 hours (or 96 hours).

### 16. Chiropractic and Acupuncture Treatment.

Fees for treatment are limited to \$35 per call with a maximum of 30 calls per year. Payments are subject to the Plan's deductible and co-insurance. Maximum X-ray charges for chiropractic services are limited to \$100 per year.

### 17. Chemical Dependency

Inpatient or Outpatient treatment shall be payable as indicated under **BEAT-IT!**

### 18. Mental Health Benefits

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

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

- a. All stages of reconstruction of the breast on which the mastectomy has been performed.
- b. Surgery on, and reconstruction of, the other breast to produce a symmetrical appearance.
- c. Prostheses.
- d. Treatment of physical complications, including lymphedemas, at all stages of mastectomy.

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

## **PRESCRIPTION DRUG PROGRAM**

**The following are your two options for getting your drug prescriptions filled:**

### **Use Your Prescription Drug Card**

Present your prescription card at a participating pharmacy along with your prescription. For a list of participating pharmacies, please contact the Plan Administrator's Office.

#### **Co-payment**

You pay the greater of 20% or \$10 per prescription.

#### **Deductible**

None. (Unless you go to a non-participating pharmacy-see below).

#### **Limitations**

- You may only purchase a 30-day supply of drugs per prescription using your prescription drug card.
- If you choose to go to a non-participating pharmacy, you will have to pay the full cost of the prescriptions and then submit a claim form to the Plan Administrator's Office for reimbursement. You will be responsible for a 50% co-payment and the drugs you get from a non-participating pharmacy will be subject to a \$50 annual deductible.

### **Order by Mail From PPS**

Submit your prescription to PPS (see the procedure below). You can order up to a 90-day supply of drugs per prescription. You should receive your medications within 10 to 14 working days from the date you mail your order.

#### **Co-payment**

You pay \$10 per brand name prescription and \$5 per generic prescription.

#### **Deductible**

None.

#### **Limitations**

Smoking cessation drugs are not available through the mail order program.

#### **Procedure**

For your first order from PPS, you will need to fill out an initial order form which you can get from the Plan Administrator's Office. Send the form, your prescriptions, and the applicable co-payments to Postal Prescription Solutions (PPS), P.O. Box 2718,

## SELF-FUNDED MEDICAL BENEFITS

Portland, OR 97208. (Please print your name and Social Security number on the back of each prescription you submit.) Re-orders can be made by telephone, mail, fax, or the PPS automated refill line. Information will be sent with your first order, but if you need help, please call PPS at 1-800-552-6694.

### **Limitations on both the participating pharmacy and mail order program:**

The following are not available through the prescription drug program:

- Non-legend drugs;
- Diabetic supplies (insulin syringes and needles are covered under the program);
- Injectable medications (other than insulin);
- Medication for weight loss, control or management;
- Dental products.

### **Important Notes:**

- **Brand name versus Generic Drugs** - Unless your doctor specifies that a brand name drug must be dispensed, if you choose to receive a brand name drug for which there is a generic equivalent, you will be responsible for paying both the applicable co-payment and the difference in price between the brand name and generic drugs. When you order by mail, PPS will automatically substitute a generic equivalent, if one is available, unless your doctor specifies that a brand name drug must be dispensed.
- **Maintenance Drugs** - Drugs that you use on a regular basis for the long-term treatment of static medical conditions, such as high blood pressure, asthma, diabetes, or arthritis are known as "maintenance drugs." Maintenance drugs should be purchased through the mail from PPS. You will be able to purchase a 90-day supply of drugs (versus only a 30-day supply with your prescription drug card) with only a single prescription and co-payment.
- If you elected medical coverage through an HMO, you must obtain your prescription drugs through the HMO.

### **SUPPLEMENTAL ACCIDENT BENEFIT (For Self-Funded Plan Participants Only)**

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

1. Surgery or medical attention performed by a legally qualified doctor of medicine.
2. Hospital care.
3. Nursing care provided by a registered graduate nurse.

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

### **PODIATRY (For Self-Funded Plan Participants Only)**

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

## SELF-FUNDED MEDICAL BENEFITS

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

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

If you have questions about foot care in general, you may call PPOC directly, (415) 928-7762, or toll free at 1-800-535-3338. If you have questions about the PPOC program, you may call PPOC directly at the toll-free number or your Medical Claims Department at (408) 279-3131.

### **ANNUAL HEALTH SCREEN (For Self-Funded Plan Participants Only)**

Self-Funded participants and their spouses are entitled to 100% coverage for annual health screens.

The annual health screen is provided to detect common disease processes in the early, most treatable stage and to emphasize the importance of maintaining a healthy lifestyle through education in personal risk reduction. Annual health screens include: chemistry panels, occult blood tests, PSA (Prostate-Specific Antigen), breast examinations, mammographies, and pap smear examinations.

### **REPLACEMENT OF ORGANS OR TISSUE**

1. The following procedures are payable on the same basis as any other illness:
  - a. Cornea transplants.
  - b. Artery or vein transplants.
  - c. Kidney transplants.
  - d. Joint replacements.
  - e. Heart valve replacements.
  - f. Implantable prosthetic lenses in connection with cataracts.
  - g. Prosthetic bypass or replacement vessels.
  - h. Bone marrow transplants.
2. The following procedures are payable on the same basis as an illness up to a lifetime maximum of \$200,000 (This maximum applies for each type of procedure and to all charges incurred as a result of the transplant(s)):
  - a. Heart transplants.
  - b. Heart and lung transplants.
  - c. Liver transplants.

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

1. The use of temporary mechanical equipment, pending the acquisition of "matched" human organ(s).
2. Multiple transplant(s) during one operative session.
3. Replacement(s) or subsequent transplant(s).
4. Follow-up expenses for covered services (including immunosuppressant therapy) up to \$10,000.

## SELF-FUNDED MEDICAL BENEFITS

The Plan will pay the expense incurred by a donor(s) up to \$10,000 for the following:

1. Testing to identify suitable donor(s).
2. The expense for the acquisition of organ(s) from a donor.
3. The expense of life support of a donor pending the removal of a usable organ(s).
4. Transportation for a living donor.
5. Transportation of organ(s) or a donor on life support.

### **Exceptions**

The Plan will not pay for:

1. any expenses when approved alternative remedies are available;
2. any animal organ or mechanical (a) equipment, (b) device, or (c) organ(s), except as provided under this provision;
3. any financial consideration to the donor other than for a covered expense which is incurred in the performance of or in relation to transplant surgery; and
4. anything excluded under the General Exclusions and Limitations.

### **Definitions**

**Transplant Surgery** means transfer of a body organ(s) from the donor to the recipient.

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

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

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

## **EXTENDED BENEFITS FOR TOTAL DISABILITY**

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

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

## **MENTAL HEALTH BENEFITS (For Self-Funded Plan Participants Only)**

Except in emergencies, you must obtain pre-certification of mental health services by calling Blue Cross at 1-800-274-7767. Blue Cross works with a network of counseling and treatment providers throughout the area. These include psychologists, psychiatrists, marriage and family counselors and social workers where needed, inpatient and outpatient hospitals, and facilities for mental health treatment.

Please note the following benefits will be provided for mental health treatment:

MENTAL HEALTH OUTPATIENT COUNSELING	Maximum* of 16 counseling sessions in a 12-month period.
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SELF-FUNDED MEDICAL BENEFITS

PSYCHIATRIC HOSPITAL CONFINEMENTS

Regular plan benefits for approved services at contracting facilities.\*\*  
In-hospital confinements are limited to 45 days per 12-month period.

PSYCHIATRIC RESIDENTIAL CARE CONFINEMENTS

Pre-approved covered charges for inpatient residential confinements at approved residential facilities for eligible Dependent children who have an AXIS I diagnosis (as defined in the Diagnostic and Statistical Manual of Mental Disorders) will be paid at 80% up to the usual, customary and reasonable (UCR) charge per day. Psychiatric Residential Care Confinements are limited to 270 days per 12-month Period.\*\*\*

\*The actual number of sessions authorized for coverage depends on the specific approved counseling plan.

\*\*Except for emergency, services at non-contracting facilities are limited to 50% of normal benefits. **For coverage, all non-emergency services require prior approval by Blue Cross. Without prior authorization, benefits will not be paid.**

\*\*\*The actual number of days authorized for coverage depends on the specific counseling plan approved by Blue Cross. **For coverage all services require prior approval by Blue Cross. Without prior authorization, benefits will not be paid.**

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

## LAB BENEFITS

### **LAB BENEFITS (For Self-Funded Plan Participants Only)**

**You have the following options for outpatient laboratory testing services:**

#### **LabOne**

Participants in the Self-Funded Plan may use the Lab Card Program to receive outpatient laboratory testing services with no out-of-pocket costs.

The next time you visit your doctor, tell them that you are a member of the LabOne Program, and be sure to show your doctor your Lab Card.

Your specimens can be drawn in your doctor's office, and the doctor may charge a reasonable fee for collecting the specimen. However, specimens must be sent to LabOne in order for you to receive this no-cost benefit. If you choose to have your doctor send your specimens to a laboratory other than LabOne, a claim will be filed and your regular benefits will apply.

If your doctor is unable to draw specimens in his/her office, simply visit one of LabOne's conveniently located, approved service centers. There is no charge for specimen collection at a LabOne service center.

You pay nothing for outpatient laboratory tests when you use your Lab Card. You also pay nothing for the collection of the specimen if you use a LabOne service center. If you have any questions regarding the Lab Card benefit, please contact LabOne at 1-800-646-7788.

### **QUALIFIED LONG TERM CARE SERVICES**

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

- (a) Conditions requiring long term care services. The individual must be certified as chronically ill by a Licensed health care practitioner. A chronically ill individual is unable to perform at least two activities of daily living without substantial assistance from another individual, due to a loss of functional capacity by reason of personal injury or sickness which can be expected to result in death or to be of long-continued and indefinite duration. Activities of daily living are eating, toileting, transferring, bathing, dressing and continence.
- (b) Waiting period. The condition that caused the individual to be unable to perform at least two activities of daily living without substantial assistance must have existed for at least twenty-four (24) months, as demonstrated by a Social Security disability award, or if no award, then satisfactory medical evidence that the condition has existed for at least sixty (60) months.
- (c) Covered services. The Plan will cover the cost of the following in-home long term care services: necessary diagnostic, preventative, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance and personal care services that are required by a chronically ill individual and provided pursuant to a plan of care prescribed by a licensed health care practitioner. The Plan may require periodic verification of the services provided.
- (d) Benefit amount. After the applicable waiting period, the Plan will pay 50% of the expense incurred for covered services up to \$15.00 per hour for a maximum of ten hours of in-home care per weekday. The provider will be reimbursed directly by the Plan.
- (e) Eligible Providers. The provider must be a licensed caregiver and cannot be a family member.
- (f) Co-payments. The Employee must pay at least 50% of the cost of the home health caregiver. The Plan will require verification of such payment at least annually.
- (g) Annual Certification by a Licensed Health Care Practitioner. The Plan shall require annual certification by a licensed health care practitioner that the individual is a chronically ill individual, as defined in this section.

## LAB BENEFITS

### **GROUP HEALTH SYSTEMS**

The Plan has also engaged Group Health Systems (GHS) to provide a network of clinical laboratories at special discount rates. If you use a participating GHS laboratory, you will receive outpatient laboratory testing services with no out-of-pocket costs. If you do not use a participating GHS laboratory (or a LabOne laboratory), the Plan will pay only 80% of the billed amount. A list of GHS facilities may be obtained from the Administrative Office.

When your doctor orders laboratory testing services, inform him or her that you are a member of the GHS laboratory program. If your doctor does not draw specimens in the office, visit the nearest participating GHS laboratory and present your Plan membership card for testing services. If your doctor draws specimens in the office, instruct the doctor's office to send the specimen to a participating GHS laboratory or request a courier pick-up. Also, ask your doctor to have a copy of your membership card accompany your specimen to the laboratory.

You pay nothing for outpatient laboratory testing when you use a GHS facility. If you receive a bill in the mail, forward it to the Administrative Office. If you have any questions about the GHS benefit, please contact GHS at 1-800-945-7708.

### **DIABETES MANAGEMENT TRAINING (For Self-Funded Plan Participants Only)**

You and your eligible Dependents may receive diabetes management training, which includes nutritional counseling, glucose testing, medications and insulin injections. The Plan will reimburse up to \$500 for the diabetes management training only once per eligible participant or Dependent in a lifetime.

### **ANNUAL HEALTH SCREEN (For Self-Funded Plan Participants Only)**

You and your eligible Dependents are entitled to 100% coverage for annual health screens without application of a deductible. Annual health screens include chemistry panels, occult blood tests, PSA (Prostrate Specific Antigen), breast examinations, mammographies and pap smears.

## EXCLUSIONS

### **EXCLUSIONS, LIMITATIONS & NON-COVERED CHARGES**

No benefits are provided for:

- (a) Services or supplies that are not medically necessary;
- (b) Any injury or sickness for which you are not treated by a legally qualified physician or surgeon;
- (c) Dentistry;
- (d) Eye refractions, or the fitting of glasses;
- (e) Injury or illness occurring in the course of employment for wages or profit;
- (f) Any injury or illness for which you could receive benefits under any worker's compensation law or occupational disease law or for which you could receive any settlement from a worker's compensation insurer;
- (g) Any service unless a charge is made for such service which the Employee is required to pay;
- (h) Cosmetic services, except for photochemotherapy treatment of vitiligo for those under age 21 (There will be a \$5,000.00 limit for this treatment.);
- (i) Experimental or investigational services;
- (j) Physical examinations;
- (k) Non-contract hospital charges for well baby care;
- (l) Confinement in a U.S. Government hospital or any surgical, medical, or other treatment, services or supplies received in or from such a hospital, or for any confinement, services or supplies furnished without charge or reimbursed by the Federal Medicare Plan, state or other governmental program or for which no charge is made that the Employee or any of his/her Dependents is required to pay;
- (m) Orthotics unless medically necessary;
- (n) Any hospitalization which is primarily for custodial care not involving medical treatment;
- (o) Family Planning: Services and supplies for artificial insemination, in vitro fertilization, infertility treatment, or surgery to reverse elective sterilization;
- (p) Radial keratotomy;
- (q) Any treatment, services, appliances or surgery related to treatment of temporomandibular joint pain or syndrome (the temporomandibular joint is the joint between the temple and the jaw), as either a medical or dental expense unless pre-approved;
- (r) Services associated with sex transformation and resulting complications;
- (s) Penile implants unless required as a result of injury or an organic disorder;
- (t) Any service or supply relating to any evaluation, treatment or therapy involving the use of high-dosage chemotherapy and adjuvant autologous bone marrow transplant, autologous peripheral stem cell rescue, or autologous stem cell rescue for any disease other than acute lymphocytic leukemia and acute non-lymphocytic leukemia, Hodgkins' disease, non-Hodgkins' lymphoma, neuroblastoma, or germ-cell malignancies; or
- (u) Any home health care, except:
  - (1) The Plan will cover the medical component of home health care provided as part of hospice due to personal injury or sickness; and

## EXCLUSIONS

- (2) The Plan will cover the medical component of home health care as approved by Blue Cross in lieu of hospitalization due to personal injury or sickness.
- (v) Losses that are due to war or any act of war, whether declared or undeclared.

# DENTAL BENEFITS

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

### **Dental Expense Benefits**

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

### **Preferred Provider Dentists**

Under this plan you are free to use any dentist. However, the Trustees have negotiated lower charges with certain dentists through DentiNex, called "preferred providers." The network of preferred providers is called "Dental Preferred Provider Organization" or "Dental PPO". Because the Plan saves money when you use a preferred provider dentist, you as a participant also save money when you use a preferred provider dentist.

Charges incurred at a PPO Dentist are paid at the In-Network level of 100% of the Contract Rate for Class I services, 80% of the Contract Rate for Class II services and 60% of the Contract Rate for Class III services. Class III Services are subject to a \$25 per person per year deductible.

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

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

### **Non-PPO Dentist**

Charges incurred at a Non-PPO Dentist will be paid at the Out-of-Network benefit level of 100% of Usual, Customary and Reasonable Charges for Class I Services, 80% of Usual, Customary and Reasonable Charges for Class II Services and 60% of Usual, Customary and Reasonable Charges for Class III Services. Class III Services are subject to a \$25 per person per year deductible.

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

### **Alternate Courses of Treatment**

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

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

### **Pre-Estimation of Costs**

Pre-estimation of treatment is requested for claims \$300 and over.

After the Attending Dentist's Statement with pre-estimation of costs has been returned to your dentist, you should discuss the computations with him/her.

## DENTAL BENEFITS

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

### **Maximum Benefits**

Benefits are payable up to a maximum of \$2,000 per person each calendar year, orthodontics up to \$2,000 per person for lifetime.

### **Covered Dental Services**

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

#### **Class I Services - Diagnostic/Preventative Services**

1. Oral examinations, including scaling and cleaning of teeth, but not more than four (4) examinations or scaling and cleaning in any period of 12 consecutive months.
2. Topical application of sodium or stannous fluoride, four (4) times in each period of 12 consecutive months, but only if the insured family member has not yet attained the age of 15 years.
3. Bite wing X-rays.

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

#### **Class II - Basic Services**

1. Dental X-rays - other than bitewing.
2. Extractions.
3. Oral Surgery, including excision of impacted teeth.
4. Fillings.
5. General anesthetics administered in connection with oral surgery or other covered dental services.
6. Prescribed drugs, premedication or analgesia (nitrous oxide).
7. Injections of antibiotic drugs by the attending dentist.
8. Space maintainers.
9. Treatment of periodontal and other diseases of the gums and tissues of the mouth.
10. Endodontic treatment, including root and canal therapy.

Class II Services will be covered at 80% of the Usual, Customary and Reasonable Charges. No deductible applies.

#### **Class III - Major Services (Formerly Class B)**

1. The initial installation (including adjustments during the six-month period following installation) of full or partial removable dentures or fixed bridgework.
2. The replacement, or alteration of, full or partial dentures, or fixed bridgework which is necessary because of:
  - (a) oral surgery resulting from an accident; or

## DENTAL BENEFITS

- (b) oral surgery for repositioning muscle attachments or for removal of a tumor, cyst, torus or redundant tissue, but only if this occurs after the protected person or Dependent has become insured under this provision and the replacement or alteration is completed within 12 months after such surgery.
- 3. The replacement of a full denture which is necessary because of
  - (a) structural change within the mouth, but only if more than five years has elapsed since the initial placement;
  - (b) the initial placement of an opposing full denture, but only after the protected person or Dependent has been covered under this provision for at least two years; or
  - (c) the prior installation of an immediate temporary denture, but only within 12 months of the installation of the temporary.
- 4. Replacement of, or addition of teeth to, an existing partial or full removable denture or fixed bridgework by a new denture or by a new bridgework, but only if
  - (a) the replacement or addition of teeth is required to replace one or more additional natural teeth extracted while insured under this provision and after the existing denture or bridgework was installed; or
  - (b) the existing denture or bridgework was installed at least five years prior to its replacement, and the existing denture or bridgework cannot be made serviceable.
- 5. The replacement of a crown restoration, provided the original crown was installed more than five years prior to the replacement.
- 6. Inlays, gold fillings, crowns, including precision attachments for dentures.
- 7. Repair or recementing of crowns, inlays, bridgework, or dentures or relining of dentures.

Class III Services will be covered at 60% of the Usual, Customary and Reasonable Charges, subject to a \$25 per person per year deductible.

### **Class IV - Orthodontic Services** (Formerly Class C)

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

Class IV Services will be covered at 60% of the Usual, Customary and Reasonable Charges subject to a \$25 per person per year deductible.

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

## **Exclusions and Limitations for the Active and Retiree Dental Plans**

### **Exclusions:**

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

## DENTAL BENEFITS

3. Expenses incurred after termination of insurance except for prosthetic devices (including bridges and crowns) which were fitted and ordered prior to termination and which are delivered to you or your insured Dependent within thirty days after the date of termination.
4. Hospitalization.
5. Facings on pontics or crowns posterior to the second bicuspid.
6. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves, and other tissues.
7. Charges for cost of replacement and/or repairs of an orthodontic appliance furnished in whole or in part under this Plan.
8. Surgical procedures for correction of malalignment of teeth and/or jaws.
9. Charges for replacement of lost or stolen appliances, dentures or bridgework.
10. Expenses covered by any other provision of this Plan.
11. Charges for completion of claims forms.
12. Charges for dental appointments that are not kept.
13. Experimental procedures.
14. Charges due to war or any act of war, whether declared or undeclared.

### **Limitations:**

The benefits as outlined are subject to the following limitations:

1. X-rays: Complete mouth X-rays are provided only once in a three- (3-) year period, unless special need is shown.
2. Prophylaxis: Prophylaxis (cleaning and scaling) including fluoride treatment for children is covered not more than four (4) times during any period of twelve (12) consecutive months.
3. Prosthodontics: Replacements will be made of an existing prosthodontic appliance only if it is unsatisfactory and cannot be made satisfactory. Prosthodontic appliances (including partial and complete dentures, crowns and bridges) will be replaced only after five (5) years have elapsed following any prior provision of such appliances.
4. In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, the Plan will pay the applicable percentage of the lesser fee. The patient is responsible for the remainder of the dentist's fee.
5. Implants (appliances inserted into bone or soft tissue in the jaw, usually to anchor a denture) are not covered by this Plan. However, if implants are provided along with a covered prosthodontic appliance, the Plan will allow the prosthodontic appliances when the prosthetic appliance is completed. The Plan will not pay for any replacement for five years following the completion of the service.

### **Claim Disputes**

See "Claims and Appeals Procedure."

# VISION CARE BENEFITS

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

Vision care benefits are provided through Vision Services Plan ("VSP"). Before making an appointment, contact VSP at 1-800-877-7195 to obtain a list of member doctors. Contact the VSP member doctor and make an appointment. Identify yourself as a VSP member and provide the doctor's office with the covered member's social security number and the Trust's name, i.e., I.B.E.W. Local 332 Health and Welfare Plan. The member doctor will call the Plan Administrators Office or VSP to verify your eligibility and plan coverage. If you are not eligible the doctors office will call to explain why and discuss available options.

When services are received from a VSP doctor, reimbursement is made directly to the doctor. The patient will have no out-of-pocket expenses other than optional items that are selected that the group does not cover. Optional items include, but are not limited to, oversize lenses, coated lenses, no-line multifocal lenses, or a frame which exceeds the plan allowance.

If services are obtained from a non-member doctor and/or dispensing optician, the bill is submitted to **Vision Service Plan at: P.O. Box 997100, Sacramento, CA 95899** and will be reimbursed according to the schedule below.

Exam	\$40	Single Vision Lenses	\$40
Bifocal Lenses	\$60	Trifocal Lenses	\$80
Frames	\$45	Tinted Lenses	\$5 (one-time payment)

### **How Often Are Services Available?**

1. **Vision Examination:** Every twelve (12) months.
2. **Lenses:** Every twelve (12) months *only if needed*.
3. **Frames:** Every twenty-four (24) months *only if needed* with the following exception: Effective January 1, 1999, every 12 months for eligible Dependents under age 14.

## **BENEFITS OF THE VISION SERVICE PLAN**

### **Vision Examination**

The primary purpose of this vision care plan is to provide for professional vision examinations. Each covered person is entitled to an examination every twelve (12) months. The examination is a complete analysis of the visual functions, including the prescription of glasses where indicated.

If the patient selects a VSP panel doctor for the examination, there is no cost.

### **Examination Procedures**

(Each test may not be indicated for every patient.)

1. **Vision Survey** - If the patient has no specific complaint but indicates a desire for a brief routine check-up, the doctor may, at his/her discretion, perform a vision survey.
2. **Vision Analysis** - If the doctor performs a complete vision analysis, it should include, but not be limited to, the following:
  - a. Visual acuity at 20 feet for each eye and for both eyes.
  - b. Visual acuity at 16 inches for each eye and for both eyes.
  - c. Cover test at 20 feet and 16 inches.

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- d. Pupillary reflexes.
- e. Test of eye movements.
- f. Ophthalmoscopy.
- g. Retinoscopy.
- h. Refraction.
- i. Coordination measurements--far and near.
- j. Additional tests as indicated such as tonometry, visual fields, biomicroscopy color vision, depth perception, etc.

### **Corrective Lenses**

When the vision examination indicates the need for corrective lenses, the VSP doctor will order the lenses from an approved ophthalmic laboratory.

The VSP doctor will verify the accuracy of the finished lenses when they are returned from the laboratory to make sure they comply with the prescription as written.

The VSP plan provides any *necessary* lenses including single vision, bifocal, trifocal, or other more complex and expensive lenses necessary for the patient's visual welfare.

Patients sometimes select lenses or lens characteristics that are not necessary for their visual welfare but are desired for cosmetic reasons. Examples are oversize lenses when large frames are selected, blended bifocals, or progressive lenses. The patient can have such lenses but is required to pay the additional cost.

### **Frames**

You are fully covered for frames up to your allowance of FORTY-FIVE DOLLARS (\$45). This allowance provides coverage for a wide selection of frames. In fact, your VSP benefit provides guaranteed savings whether you choose a frame that is covered in full or one that exceeds the plan's allowance. If you choose a frame valued at more than the plan's allowance, you will receive a twenty percent (20%) discount on the amount over your allowance. Have your doctor help you choose the best frame for you based on your needs.

### **Value-Added Discounts**

Your plan also provides a twenty percent (20%) discount on additional pairs of prescription glasses (lenses and frame), including prescription sunglasses. Simply return to the same VSP doctor who performed your last covered eye exam within twelve (12) months from the date of the exam.

### **Contact Lenses**

Medically necessary contact lenses may be prescribed by a VSP doctor for certain conditions. A VSP doctor must receive prior approval from VSP for medically necessary contact lenses. If the request is approved, then the contact lenses are fully covered by VSP. If you go to a non-member provider and prior approval is secured, VSP will pay up to TWO HUNDRED AND TEN DOLLARS (\$210).

Because of the complex nature of this type of benefit, it is sometimes necessary for the patient to pay some additional cost. These problems are resolved on a case-by-case basis.

When the patients choose contact lenses, there will be an allowance of ONE HUNDRED AND FIVE DOLLARS (\$105) toward the cost of the contacts and the exam is covered in full.

### **Safety Eyewear**

Safety eyewear that meets ANSI and OSHA standards will be covered for all Active Employees. The safety eyewear may be obtained only from a VSP member doctor.

## VISION CARE BENEFITS

### **Vision Therapy**

Vision Therapy treats severe visual problems associated with the muscular coordination of the eyes. If you are covered under this benefit, you are entitled to Vision Therapy and associated materials.

When a VSP doctor suspects a problem with the visual functions and prescribes Vision Therapy, the VSP doctor must receive prior approval from VSP before Vision Therapy is covered. VSP may authorize supplemental testing by the doctor to determine the nature of the problem and to allow the doctor to gather enough facts to propose a treatment plan. This benefit is paid by the Plan with no co-payment to you. The treatment plan must then be submitted to VSP for approval.

Once the treatment plan has been approved, you will pay twenty-five percent (25%) of the costs. The total maximum benefit available to any covered person under this subsection will be Seven Hundred and Fifty Dollars (\$750), excluding co-payments, with you paying twenty-five percent (25%). In addition, if supplemental testing is approved, VSP will pay up to Eight-Five Dollars (\$85) annually.

If you use a non-member doctor for this benefit, you should pay the provider in full and remit your reimbursement as described above. You will be reimbursed by VSP in accordance with an amount not to exceed what VSP would pay a provider in similar circumstances. THERE IS NO ASSURANCE THAT THIS AMOUNT WILL BE WITHIN THE TWENTY-FIVE PERCENT (25%) CO-PAYMENT FEATURE.

### **Exclusions and Limitations**

#### **Extra Cost:**

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

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

#### **Not Covered:**

There is no benefit for professional services or materials connected with any of the following:

1. Orthoptics or vision training, and any associated supplemental testing.
2. Plano lenses.
3. Two pair of glasses instead of bifocals.
4. Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.

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5. Medical or surgical treatment of the eyes.
6. Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.
7. Services or materials for any injury or illness occurring in the course of employment for wages or profit; services or materials for any injury or illness covered by Workers' Compensation Law or similar legislation, or obtained through or required by any government agency or program whether federal, state, or any subdivision thereof, except VSP will pay benefits if the State of California makes a charge for these benefits and if the service is provided by the State of California.
8. Perceptual training for a learning disability.

### **Grievance System**

If you have a complaint or grievance regarding VSP service or claim payment, you may communicate your grievance to VSP by calling the VSP Customer Service Department toll free at (800) 877-7195, Monday through Friday, 6:00 a.m. to 6:00 p.m., Pacific Standard Time. You may also file a complaint or grievance in writing with VSP at 3333 Quality Drive, Rancho Cordova, California 95670. If you have an emergency grievance or your grievance has not been satisfactorily resolved by VSP, you may contact the California Department of Corporations, Health Plan Division toll free at (800) 400-0815 or visit the Department's website <http://www.corp.ca.gov>. The hearing and speech impaired may contact the Department toll free at (800) 435-2929 or (888) 877-5378.

## SMOKING CESSATION BENEFITS

### **SMOKING CESSATION PROGRAM FOR ACTIVE AND CATEGORY 2 EMPLOYEES, DEPENDENTS AND RETIREES**

The Plan will reimburse up to a maximum of \$300 for nicotine transdermal patches when prescribed by your physician as part of a three-month program to stop smoking and after the following conditions are satisfied:

- You attend a smoking cessation class, such as the one the American Cancer Society offers, and submit a certificate of completion. The name of their stop smoking program is "Fresh Start" and the local chapter telephone number is (408) 287-5973.
- You obtain a statement from your physician that you are tobacco-free.

Submit the prescription for the nicotine transdermal patches, along with the certificate of completion from a smoking cessation class and your physician's statement that you are tobacco-free, to the Plan Administrator's Office for reimbursement of up to \$300 for the nicotine transdermal patches.

The Plan will reimburse up to \$300 for the nicotine transdermal patches only once per eligible participant or Dependent in a lifetime.

# HEARING CARE BENEFITS

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

Hearing care, which is provided by or ordered by a physician or certified audiologist, is subject to the following limits:

1. \$30 for one hearing examination in a 24-month period.
2. The first \$500 for each hearing device paid in full and 50% of any additional up to a maximum of \$1,000 Plan payment.
3. Limit of two hearing devices in a two-year period.

# CHEMICAL DEPENDENCY BENEFITS

## **BEAT IT! PRESCRIPTION FOR CHEMICAL DEPENDENCY FOR ACTIVE AND CATEGORY 2 EMPLOYEES, DEPENDENTS AND RETIREES**

Beat It! is a specialty program for the treatment of problems with alcohol and drug abuse. This program is available to all qualified participants and their eligible Dependents, including members who have chosen the Kaiser, Health Net or PacifiCare plan for medical coverage.

The benefits include twenty-eight (28) day inpatient treatment in a **pre-approved** facility or an outpatient counseling program with a **pre-approved** counselor. These benefits are paid at 100% for first-time use of the program, inpatient or outpatient. Second-time use of the program will be paid at 80%. Alcohol and drug treatment benefits are subject to a lifetime maximum of \$25,000.

Inpatient modalities are flexible and depend on the need of the client. **These facilities may not be the same as the contract facilities for the medical inpatient program.** All inpatient programs include six months to one year of aftercare and family involvement.

Outpatient counseling with approved counselors includes forty (40) hours of one-on-one therapy sessions.

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

**Pre-admission/pre-treatment approval is mandatory.**

All calls and information are confidential.

<p><b>BEAT IT! (408) 436-2392 1-800-828-3939</b></p>
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# RETIREE PLAN (BUE)

## **RETIREE PLAN FOR BARGAINING UNIT EMPLOYEES (BUE)**

The Trustees have established the Retiree Plan of the I.B.E.W. 332 Health & Welfare Trust Fund on the basis that the employer contributions on the Active Employees will, if continued, maintain this plan for Retirees. At the present time, eligible Retirees pay no charge for the Retiree Plan if they have qualified for Medicare. The entire cost of their benefits is subsidized from employer contributions earned by Active Employees. Eligible Retirees who do not qualify for Medicare still receive a partial subsidy from employer contributions earned by actives. However, it is recognized that the benefits provided by this Plan can be paid only to the extent that the Trust has available adequate resources for those payments. The Trustees retain the right in their sole discretion to reduce benefits of the Retiree Plan, to reduce or eliminate the subsidy for benefit coverage to the Retirees, and to use Trust reserves for benefit coverage for Active Employees or Retirees. The Retiree coverage is not a vested benefit. This benefit is provided at the sole discretion of the Trustees.

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

### **Minimum Eligibility Requirements for All Retirees**

1. You must be retired under the I.B.E.W. Local 332 Pension Plan Part A or B.
2. You must be age 62 or over.
3. You must be drawing Social Security benefits.
4. You must have been covered under the Active Employee Plan for a minimum of 55 of the last 60 covered months immediately prior to retirement. (All months of coverage as an active participant, including months of self-payment, will be considered in determining your eligibility under this rule. If you retire on or after age 60 under the I.B.E.W. Local 332 Pension Plan Part A or B, you may make self-payments at the prescribed rate for continued coverage under any one of the Active Plans for up to 24 months, and any such months of self-payment will be counted in determining whether you are eligible for coverage under the Retiree Plan when you reach age 62.)
5. If you are eligible for Medicare, you must enroll in both Part A and Part B of Medicare and must assign your Medicare Part B payments to the Medicare Supplement Plan you select, as described below. If your spouse is eligible for Medicare, he/she must enroll in Part A and assign the Part B payments to the Medicare Supplement Plan he/she selects.
6. If you are not eligible for Medicare, you must make a monthly payment to the Plan to help cover the cost of your benefit coverage. The amount of the monthly payment is established by the Board of Trustees. Payments for the Retiree and spouse must be made without interruption. If there is a lapse in payments the coverage will terminate and cannot be reinstated.
7. You must apply for the Retiree Plan through the Plan Administrator.
8. Employees who obtain disability retirement under the I.B.E.W. Local 332 Pension Plan and who also fulfill the minimum coverage requirements shall be eligible, after exhausting the maximum 12-month free disability coverage and any individual reserve, to make self-payments under the Regular Plan for Active Employees until age 62, at which time the Employee may transfer to the Retiree Plan.

## RETIREE PLAN (BUE)

### **Retiree Health Benefits**

As a Retiree, you have the choice of four different medical providers: Kaiser Foundation, Health Net, PacifiCare/Secure Horizons Plan, and the UNIONCARE Plan F Medicare Supplemental Plan. All Retirees have vision, hearing care and Retiree dental benefits under the Self-Funded Plan, as well as the Beat It! program for chemical dependency.

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

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

The Self-Funded Plan includes all the covered charges listed under the Active Plan with benefits provided on the basis of a \$100 per individual calendar year deductible, with a 80%-20% co-insurance feature up to the individual's maximum benefit. The maximum benefit depends on the Retiree's months of coverage under the Active Plan during the period immediately prior to retirement (including months of self-payment coverage). If the Retiree had Active Plan coverage for at least 120 of the last 144 months prior to retirement, the maximum is \$15,000 per individual per lifetime. If the Retiree had Active Plan coverage for at least 180 of the last 216 months before retirement, the maximum is \$30,000. If the Retiree had Active Plan coverage for at least 240 of the last 288 months before retirement, the maximum is \$60,000. A Retiree's (or Retiree's spouse's) maximum shall be increased from \$30,000 to \$60,000 if all the following conditions are met: (a) the Retiree had Active Plan coverage for at least 18 consecutive years immediately prior to retirement; (b) the Retiree (or the Retiree's spouse) incurs medical expenses in excess of \$30,000 for the treatment of a single, catastrophic illness or injury; and (c) the Retiree or spouse had no opportunity to change to HMO coverage during a regular or special open enrollment period after the onset of the illness or injury but before the treatment expenses exceeded \$30,000. This rule is intended to provide interim protection while Retirees evaluate their medical coverage needs and shall not apply to any expense incurred before January 1, 1997 or after September 30, 1997. The Utilization Review Program and the list of Preferred Provider Organization (PPO) providers should be reviewed prior to any hospitalization under the Self-Funded Plan. The list of PPO providers is provided to you automatically and free of charge as a separate document.

### **Out-of-Area Retirees**

The following rules apply to Retirees who are eligible for the Retiree Plan but who live outside any geographic area served by Kaiser, Health Net, or PacifiCare/Secure Horizons:

1. Retirees And/Or Spouses Who Are Medicare-Eligible. Medicare-eligible Retirees who reside outside the HMO service area may elect the UNIONCARE Plan F Medicare Supplemental Plan for themselves and their eligible spouses. **The monthly premium for UNIONCARE coverage is paid by the Plan. If a Medicare-eligible Retiree elects coverage under a different Medicare Supplemental Plan, the trust will pay reimbursement toward the cost of each Medicare-eligible Retiree or Medicare-eligible spouse of a Retiree.** Reimbursement is paid monthly up to a maximum of \$150 per month per eligible Retiree or spouse (\$300 if both the Retiree and spouse are enrolled in a Medicare Supplemental Plan). To obtain reimbursement, the Retiree must submit the bill and canceled check to the Administrative Office.
2. Retirees And/Or Spouses Who Are Not Medicare-Eligible. Retirees who are not yet eligible for Medicare and who reside outside the HMO service area may obtain reimbursement toward the cost of an alternative pre-paid health plan. The monthly payment to the Retiree Plan for pre-Medicare coverage (currently \$50 per eligible pre-Medicare Retiree or spouse) is subtracted from the total reimbursement amount. The net reimbursement amount is paid monthly up to a current maximum of \$200 per Retiree or spouse (\$400 if both the Retiree and spouse are enrolled in the alternative health plan). To obtain reimbursement, the Retiree must submit the bill and canceled check to the Administrative Office. When the Retiree or spouse becomes eligible for Medicare, he/she must enroll in a Medicare Supplement Plan as described above. Reimbursement under this paragraph cannot be used to pay any part of the cost of group health coverage provided to the Retiree or the Retiree's spouse by an employer, unless the Retiree and/or the Retiree's spouse is required to pay all or part of the cost of group health coverage.

## RETIREE PLAN (BUE)

### **Effective Date of Coverage**

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

### **Delayed Effective Date While Covered by Spouse's Plan**

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

### **Changes to Report**

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

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

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

### **Termination Upon Returning to Active Status**

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

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

### **Termination of Coverage**

Your coverage will terminate if the Plan is terminated, your maximum benefit has become payable, or you cease to be a member of a class eligible for coverage under the Retiree Plan.

Coverage for your spouse will terminate when he/she ceases to be an eligible Dependent (e.g., divorce), when the Plan is terminated, when your spouse's maximum benefit has become payable, when you cease to be eligible for spouse's coverage, or when your own coverage terminates, except that termination of your coverage by reason of payment of the maximum benefit will not require termination of coverage for your spouse. Similarly, if coverage for your spouse is terminated by reason of payment of the maximum benefit, your coverage will continue.

If your coverage under the Plan ceases because of your death, coverage may be continued by your surviving spouse. Your surviving spouse must contact the Administrative Office to determine if coverage is to continue. Coverage will be continued on the same basis for your surviving spouse except that the coverage will cease when your spouse remarries or dies, subject to the COBRA requirements.

### **Extended Coverage Benefits of Active Plan**

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

## RETIREE PLAN (BUE)

### **Material Handlers and Residential Wiremen**

An individual who is otherwise eligible for the Retiree Plan for Bargaining Unit Employees, but cannot retire under the I.B.E.W. Local 332 Pension Plan Part A or B, may participate in the Retiree Plan if he or she was employed as a material handler or residential wiremen under a collective bargaining agreement negotiated by I.B.E.W. Local 332 for at least twenty (20) consecutive years immediately prior to retirement.

### **General Exclusions**

Exclusions under the Retiree Plan are subject to the HMO Contracts (Kaiser Foundation, Health Net and PacifiCare/Secure Horizons) and Insurance Contracts (Monumental Life Insurance Company/UNIONCARE). Dental Exclusions and Limitations under the Retiree Dental plan are listed in the section entitled "Exclusions and Limitations for the Active and Retiree Dental Plans." Exclusions under the Self-Funded Medical Plan are listed on in the section entitled "Exclusions, Limitations and Non-Covered Charges."

# PRE-FUNDED EARLY RETIREE PLAN (BUE)

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

If at the time you retired you were eligible for coverage under the Plan as an Active Employee and you meet the following requirements, you and your spouse will be eligible to participate in the Pre-Funded Early Retiree Plan. The Pre-Funded Early Retiree Plan provides for up to sixty (60) consecutive months of coverage for retired Bargaining Unit Employees between the ages of fifty-seven (57) and sixty-five (65) through one of three HMO plans (Kaiser, Health Net, or PacifiCare). This coverage will be provided at no cost to the Retiree or spouse.

### **Eligibility Rules**

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

- 1) You are retired and receiving benefits under I.B.E.W. Local 332 Pension Plan Part A or B;
- 2) You are between the ages of fifty-seven (57) and sixty-five (65);
- 3) You have had one hundred and twenty (120) months of coverage in the last one hundred and eighty (180) months under the I.B.E.W. Local 332 Health and Welfare Plan as an Active Employee and were eligible under the Plan immediately prior to your retirement date; and
- 4) You have exhausted your Bank Reserve:
  - Coverage months include coverage earned as a result of employer contributions, self-pay, or coverage earned as a result of reciprocal transfers of employer payments.
  - If you have not used the full sixty (60) months of coverage, but you reach age sixty-five (65), your coverage under the Pre-Funded Early Retiree Plan will terminate. Coverage will also terminate for your spouse regardless of his or her age.
- 5) You must apply to the Pre-Funded Early Retiree Plan through the Plan Administrator.

### **Effective Date of Coverage**

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

- 1) Attained age fifty-seven (57);
- 2) Exhausted his or her Bank Reserve; and
- 3) Completed an application for participation that has been approved by the Board of Trustees or the Plan Administrator.

### **Spouse Coverage**

Your spouse receives free coverage while you are participating in the Pre-Funded Early Retiree Plan regardless of his or her age.

### **Out-of-Area Early Retiree**

If you reside outside the service area of the three available HMO plans, the Plan will provide a premium reimbursement toward the cost of an alternative pre-paid health plan subject to the Out-of-Area rules for participants in the Retiree Plan. The premium reimbursement amount is paid monthly up to a current maximum of TWO HUNDRED AND FIFTY DOLLARS (\$250) per Retiree or spouse (FIVE HUNDRED DOLLARS (\$500) if both the Retiree and spouse are eligible). Please refer to the rules for Out-of-Area Retirees.

## PRE-FUNDED RETIREE PLAN (BUE)

### **Pre-Funded Early Retiree Plan Benefits**

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

### **Termination of Coverage**

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

After coverage under the Pre-Funded Early Retiree Plan terminates, you and/or your spouse will be eligible for medical, hearing, vision care, the Beat It! program and Retiree Dental Benefits under the Retiree Plan. When Pre-Funded Early Retiree Plan coverage terminates, coverage under the Self-Funded Dental Plan for Active and Category 2 Employees and Dependents terminates.

### **Examples**

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

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

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

### **Rules for eligible participants retiring before January 1, 2002**

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

# RETIREE PLAN (NBUE)

## **RETIREE PLAN FOR NON-BARGAINING UNIT EMPLOYEES (NBUE)**

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

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

All provisions of the Retiree Plan shall apply to this Retiree Plan for Non-Bargaining Unit Employees except Non-Bargaining Unit Employees are not eligible for the Pre-Funded Early Retiree Plan and are subject to the following payment requirements.

### **Required Payment:**

Normal - 65 years of age or older .....	\$50 per month
Early - 62 years of age, but less than 65 years of age .....	\$75 per month

An Employee, who experiences a Total Disability and is under the age of 65, may make self-payments under the Plan for Non-Bargaining Unit Employees at the same rate set forth for this group of Employees until approved for Medicare benefits, at which time the disabled Employee would be eligible for the Retiree Plan at the \$50 per month rate.

### **Spouse of Retiree or Totally Disabled Employee:**

65 years of age or older .....	\$50 per month
Less than 65 years of age .....	\$75 per month

### **Kaiser Plan, PacifiCare, or the Health Net Plan**

All Retirees of the Plan (including Normal, Early and Disabled) who are participants in the Kaiser Permanente, Health Net Plan or PacifiCare at the time of retirement shall be permitted to continue their coverage with Kaiser Permanente, Health Net Plan, or PacifiCare. The Secure Horizons Plan and the UNIONCARE Plan will also be available for Medicare-eligible Retirees.

# RETIREE DENTAL PLAN

## **Retiree Dental Benefits For Bargaining and Non-Bargaining Eligible Retirees**

### **Dental Expense Benefits**

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

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

The In-Network benefit level for Retiree Dental Benefits is one hundred percent (100%) of the Contract Rate for Class I services and, sixty percent (60%) of the Contract Rate for Class II and Class III services. Class II and Class III Services are subject to a TWENTY-FIVE DOLLAR (\$25) per person per year deductible.

The Out-of-Network benefit level for Retiree Dental Benefits is one hundred percent (100%) of Usual, Customary and Reasonable Charges for Class I Services and, sixty percent (60%) of Usual, Customary and Reasonable Charges for Class II and Class III Services. Class II and Class III Services are subject to a TWENTY-FIVE DOLLAR (\$25) per person per year deductible.

### **Maximum Benefits and Annual Deductible**

Benefits are payable up to a Maximum of FIFTEEN HUNDRED DOLLARS (\$1,500) per person each calendar year.

### **Covered Dental Services**

"Covered Dental Services" shall be deemed to have incurred on the date the dental service is performed. Covered dental services are organized into three (3) "classes": Class I Diagnostic/Preventive Care, Class II Basic Services and Class III Major Services. The services covered under each Class are listed in the "Dental Benefits" section of this Plan booklet. There is one major change: Class II Services will be covered at 60% of the Usual, Customary and Reasonable Charges under the Retiree Plan. In addition a \$25.00 deductible applies.

The Retiree Plan does not provide Class IV Orthodontia Services.

### **Exclusions and Limitations**

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

# DISABLED PARTICIPANTS

## **1. Health and Welfare Coverage for Disabled Participants**

- a. If you become disabled and are unable to work while covered under this Plan, your coverage may be extended without deduction from your reserve bank of dollars and at no cost to you, for up to twelve (12) months (a lifetime maximum). If you prefer, you may use some or all of your reserve bank of dollars before commencing the 12-month free extension. Contact the Plan Administrator's Office to determine the month in which the free coverage will begin.
- b. The above will provide you and your eligible Dependents with the same benefits as if you were still employed and at no cost to you.
- c. You must provide the Plan Administrator's Office with proof of disability by submitting the completed short-term disability application or a medical claim form with the physician's statement of disability completed by your doctor.
- d. If you are still disabled and unable to work after you have used the 12-month free extension, any remaining balance in your reserve bank of dollars will be used to continue your health coverage. You may have a maximum of \$7,200 in your reserve bank and, of course, you may have less.
- e. Contact the Plan Administrator's Office to determine your reserve bank balance and the time period for which your reserve bank will cover you.

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

- a. Health and Welfare Coverage under the I.B.E.W. Local 332 Health and Welfare Plan is available for an unlimited number of months on a self-pay basis for disabled participants who meet the following conditions: (1) you are retired under the I.B.E.W. Local 332 Pension Plan (Part A and/or Part B) and (2) you have been insured under the I.B.E.W. Local 332 Health and Welfare Plan for a minimum of sixty (60) months immediately preceding retirement (coverage may either be from self-pay or by working hours for a contributing employer or a combination thereof). Self-payments must commence in the month immediately following the last month of coverage available through active work or reserve hours. Those Employees who do not meet the above qualifications can utilize the self-payment basis explained in the "Self-Payment" section of this Plan booklet. Non-Bargaining Unit Employees must meet all conditions listed above except the pension requirements.
- b. Disabled Employees receiving an I.B.E.W. Local 332 disability pension and who are under age 62 and not yet eligible for Medicare benefits may self-pay their Health and Welfare premium for the Plan benefits. You may continue to self-pay until you reach age 62 at which time you may transfer to the Retiree Plan. A disabled Employee may transfer to the Retiree Plan earlier than age 62 if approved for Medicare Benefits and the 60-month requirement as stated in 2a is met.
- c. Contact the Plan Administrator's Office for the self-pay premium amount for the Plan benefits.
- d. Refer to the "Self-Payment" section of this Plan booklet for further information.
- e. Disabled Employees over age 62 may transfer to the RETIREE MEDICAL PLAN. Contact the Administrative Office for the Retiree medical application to do this. The Retiree Plan includes hospital, medical, and vision coverage. It does not include Life Insurance, Accidental Death & Dismemberment, Short Term Disability, or Dental coverage. The eligibility requirements and individual maximums are set forth in the "Retiree Plan" section of this benefit booklet.
- f. You are eligible for up to ten (10) months of additional free coverage after you have exhausted the 12-month extension and your reserve bank, provided you have had at least ten (10) years of continuous coverage under the Plan immediately prior to the disability, you have obtained a Social Security Disability Award, and you are not yet covered by Medicare. To remain eligible for free coverage, you must elect an HMO option during the first open enrollment period following the commencement of this special extension. The additional period of free coverage ends on the date that you become covered by Medicare based on the Disability Award.

## DISABLED PARTICIPANTS

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

- a. If you become totally disabled while insured under the Plan, your Health and Welfare coverage will be extended as provided in the "Self-Payment" section of this benefit booklet. Thereafter, should your continuous coverage terminate, you will continue to be eligible for comprehensive medical expenses incurred **ONLY FOR THE ILLNESS OR INJURY WHICH CAUSED THE DISABILITY** and only for a maximum of twelve (12) months. This additional extension does not cover you for illness or injury not related to the disability and does not provide coverage for your Dependents.
- b. Your life insurance remains in effect until you attain age 70 or cease to be totally disabled, provided you became disabled before age 60 and while you were covered under the Active Plan. Coverage may end sooner if the policy terminates or if you fail to provide proof of disability required by the insurance company.
- c. Before an extension of benefits is granted, you must have a medical claim form filled out and signed by your doctor attesting to total disability; this must be done annually. The completed medical form is to be given to the Administrative Office medical claims department.
- d. The extension of benefits is available at no cost to you.
- e. Refer to the "Life Insurance" section for the life insurance extension and to the "Self-Payment" section for the medical extension information.

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

- a. Upon the death of a disabled Employee covered under the Active Plan, the surviving covered Dependents may continue to purchase coverage for the same time period and with the same limitations as if the Employee had survived, provided that such period equals or exceeds the applicable eligibility period allowed under the COBRA rules in the "Self-Payment" section. If an Employee's surviving spouse remarries, coverage for the surviving spouse and Dependent children of the deceased Employee may be continued. Benefits will not be provided to the new husband or wife of the surviving spouse nor to any children of that person.
- b. Upon the death of a disabled Retiree covered under the Retiree Plan, the surviving spouse may continue to purchase coverage for the same time period and with the same limitations as if the Retiree had survived, provided that such period equals or exceeds the applicable eligibility period allowed under the COBRA rules set forth in the "Self-Payment" section. If a Retiree's surviving spouse remarries, coverage for the surviving spouse may be continued. Benefits will not be provided to the new husband or wife of the surviving spouse.

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

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

# SUMMARY PLAN DESCRIPTION

**A. Name of Plan:**

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

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

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

<b>Mailing Address</b>	<b>Physical Address</b>
Board of Trustees of the I.B.E.W. Local 332 Health and Welfare Trust P.O. Box 5057 San Jose, CA 95150-5057	Board of Trustees of the I.B.E.W. Local 332 Health and Welfare Trust 1120 South Bascom Avenue San Jose, CA 95128

Telephone: (408) 288-4400

**C. Identification Number:**

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

**D. Type of Plan:**

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

**E. Type of Administration:**

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

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

<b>Mailing Address</b>	<b>Physical Address</b>
Board of Trustees of the I.B.E.W. Local 332 Health and Welfare Trust P.O. Box 5057 San Jose, CA 95150-5057	Board of Trustees of the I.B.E.W. Local 332 Health and Welfare Trust 1120 South Bascom Avenue San Jose, CA 95128

Telephone: (408) 288-4400

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

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

George Kraw  
Kraw & Kraw  
Riverpark Tower, Suite 200  
333 West San Carlos Street  
San Jose, CA 95110

## SUMMARY PLAN DESCRIPTION

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

#### **Labor Organization Trustees:**

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

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

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

Robert V. Tragni  
I.B.E.W. Local 332  
2125 Canoas Garden Ave.  
Suite 100  
San Jose, CA 95125

#### **Employer Trustees:**

William T. Barrow, Chairman  
NECA—Santa Clara Valley Chapter  
P.O. Box 28899  
San Jose, CA 95159-8899

John Casey  
Bevans Electric  
500 Coleman Avenue  
San Jose, CA 95110

Patrick L. Mark  
Mark Electric Co.  
1027 Chestnut Street  
San Jose, CA 95110

Richard A. Morin  
Ray Scheidts Electric, Inc.  
1055 N. 7th St.  
San Jose, CA 95112

### **I. Description of Collective Bargaining Agreements:**

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

### **J. Eligibility, Termination of Eligibility and Benefits:**

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

### **K. Source of Contributions:**

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

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

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

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

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

## SUMMARY PLAN DESCRIPTION

### ***Preferred Provider Organization***

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

Blue Cross of California  
BC Life and Health Insurance Company  
21555 Oxnard Street  
Woodland Hills, CA 91367

### ***Utilization Review Organization***

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

Blue Cross of California  
BC Life and Health Insurance Company  
21555 Oxnard Street  
Woodland Hills, CA 91367

### ***Health Maintenance Organizations***

Employees and Dependents have the option of selecting medical coverage from three health maintenance organizations. The medical benefits are insured and provided under contracts between the Trust and Health Net of California, Inc., PacifiCare of California and the Kaiser Foundation Health Plan. Health Net of California, Inc., PacifiCare of California and the Kaiser Foundation Health Plan are responsible for administering their own plans and paying the claims.

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

Health Net of California, Inc.  
155 Grand Avenue, 3rd Floor  
Oakland, CA 94612

PacifiCare of California  
5701 Katella Avenue  
Cypress, CA 90630

### ***Mail Order Prescription Drug Program***

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

Postal Prescription Services  
P.O. Box 2718  
Portland, OR 97208

## SUMMARY PLAN DESCRIPTION

### ***Prescription Drug Program***

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

Pharmaceutical Care Network  
9343 Tech Center Drive  
Suite #200  
Sacramento, CA 95826

### ***Vision Plan***

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

Vision Service Plan  
3333 Quality Drive  
Rancho Cordova, CA 95670

### ***Life and Accidental Death and Dismemberment Insurance***

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

The Principal Life Insurance Company  
Des Moines, IA 50392-0002

### ***Substance Abuse Program***

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

Beat It! Program, Inc.  
1796 Technology Drive  
San Jose, CA 95110

### ***Podiatry Plan***

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

Podiatry Plan of California  
203 Willow Street  
San Francisco, CA 94109

### ***Laboratory Preferred Provider Organization***

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

Group Health Systems  
P.O. Box 40  
McArthur, CA 95056

### **M. Plan Year:**

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

## SUMMARY PLAN DESCRIPTION

### **N. Statement of ERISA Rights:**

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

#### ***Receive Information About Your Plan and Benefits***

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

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

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

#### ***Continue Group Health Plan Coverage***

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

#### ***Demonstrate Creditable Coverage to Reduce or Eliminate Preexisting Condition Exclusion Period***

Demonstrate creditable coverage under another group health plan in order to reduce or eliminate the preexisting condition exclusion period under your group health plan. You should be provided with a certificate of creditable coverage, free of charge, from a group health plan or health insurance issuer at the following times: (1) when you lose, or would lose in the absence of COBRA continuation coverage, coverage under the plan; (2) when your COBRA continuation coverage ceases; and (3) when you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion in your coverage for six (6) months after your enrollment date.

#### ***Prudent Actions by Plan Fiduciaries***

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

#### ***Enforce Your Rights***

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

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to One Hundred and Ten Dollars (\$110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan

## SUMMARY PLAN DESCRIPTION

fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### ***Assistance with Your Questions***

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

### **O. Relationship Between Plan and Providers of Medical Services**

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

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

### **P. Plan Amendment and Termination:**

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

# GENERAL PROVISIONS

## **Processing and Payment of Claims**

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

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

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

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

1. You will be reimbursed for the Plan's share of the cost, provided benefits were not assigned; or
2. The provider will be reimbursed for the Plan's share of the cost.

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

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

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

All assignments for payment of claims require original signature of the participant.

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

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

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

1. Part I completed and signed by the participants.

If an accident, you must give complete information as to date, time, and place.

2. Part II completed by the attending physician ONLY. (We do not need claim forms completed by the lab technologist, radiologist, or consulting physician.)
  - a) Only one claim form is needed for a continuing illness every few months.
  - b) A new claim form is required for each new illness and each accident.
  - c) Identify all subsequent bills with your local union name and number.
  - d) Assignment of benefit payment will only be honored upon the participant's personal signature.
3. Claims received more than twelve (12) months after the expense is incurred will not be paid unless the Employee provides satisfactory evidence that he/she has remained continuously disabled from the inception of the disability absence through the date the application is received. Any claim for the short-

## GENERAL PROVISIONS

term disability benefit which is not received by the Plan within sixty (60) days of the disability absence will not be paid.

### **How to File a Dental Claim**

1. Obtain a claim form from your Union Office or Plan Administrator.
2. Complete the employee portion of the claim form.
3. Have your dentist complete his/her portion of the claim form.
4. Upon completion of the claim form, attach itemized bills and return your claim form to:

#### **Mailing Address**

Board of Trustees  
of the I.B.E.W. Local 332  
Health and Welfare Trust  
P.O. Box 5057  
San Jose, CA 95150-5057

#### **Physical Address**

Board of Trustees  
of the I.B.E.W. Local 332  
Health and Welfare Trust  
1120 South Bascom Avenue  
San Jose, CA 95128

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

### **Claims and Appeals Procedures**

Claims should be filed with the Plan Administrator. Contact the Plan Administrator for forms and instructions for making a claim.

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

#### Concurrent Care Claims

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

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

#### Pre-Service Claims

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

#### Post-Service Claims

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

## GENERAL PROVISIONS

### Disability Claims

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

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

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

3. Review procedure:

- a) Where a claim has been denied or partially denied, you may appeal the denial and be given an opportunity for review.
- b) Within one hundred and eighty (180) days after you have received written notice that your claim has been denied, you or your representative may make a written request for review to:

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

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

- c) A written request for review must set forth all the grounds upon which it is based, together with any supporting facts, including comments, documents and records, and any other matters which you feel support your claim, and this information will be considered in determining your appeal.
- d) Upon request and free of charge, you may have access to, and copies of, any relevant documents of the Trust or insurance company, including the name of the medical or vocational expert whose advice was obtained in connection with the appeal, without regard to whether the advice was relied upon in making the initial benefit determination.
- e) Your appeal will not be reviewed by the same individual who made the initial determination nor a subordinate of such person, and the initial determination will not be given any deference in deciding your appeal.
- f) A health care professional with the appropriate training and experience will be consulted in any appeal based in whole or in part on medical judgment, and such health care professional will be neither the health care professional consulted in the initial determination nor the subordinate of such health care professional.

## GENERAL PROVISIONS

- g) Within a reasonable time after receipt of your request for review for **post-service** claims, you will be notified as to the date, time, and place of the hearing by regular mail to the address as shown on your request for review.
- h) You may be represented at such hearing by an attorney or any other representative of your choosing at your own cost and expense.
- i) The Board of Trustees has full discretionary authority to interpret all Plan documents and to make all factual determinations concerning your claim.

### 4. Decision on review:

#### Pre-Service Claims

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

#### Post-Service Claims

A decision will be made promptly and not later than sixty (60) days after the receipt of your request for review.

#### Disability Claims

A decision will be made promptly and not later than forty-five (45) days after the receipt of your request for review.

The decision on review will be in writing and will include (a) specific reasons for the denial, (b) a reference to the specific Plan provisions on which the determination is based, (c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, (d) a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures, (e) a statement of your right to bring an action under ERISA Section 502(a), (f) the specific rule, guideline, protocol, or other similar criterion, if any, relied upon in making the determination, and (g) an explanation of the scientific or clinical judgment for the determination if the denial was based on medical necessity or other similar exclusion or limit.

The decision of the Board of Trustees on review shall be final. No lawsuit may be filed without exhausting the above review procedure. In any such lawsuit, the decision of the Board of Trustees will be subject to judicial review only for abuse of discretion. No legal action may be commenced or maintained against the Trust or Plan more than two (2) years after the claim has been denied.

### **No Vested Right to Benefits**

#### **Covered Employees or Dependents do not have a vested right to the benefits provided under the Plan.**

Benefits may be modified, reduced or eliminated in the future and any such change will apply to charges incurred for services or supplies on or after the effective date of the modification, reduction or elimination. The Plan will not pay benefits for charges incurred by a person after that person terminates participation in the Plan.

### **Conditional Payment**

If a covered Employee or Dependent has medical expenses as a result of an injury or accident for which a third party is, or may be, held responsible, the Plan may make advance payments on behalf of such Employee or Dependent, subject to the Plan's subrogation rights. Before any such payments will be conditionally made, the covered Employee or Dependent (or the Dependent's legal guardian if the Dependent is a minor) shall execute an agreement that acknowledges and affirms (1) the conditional nature of the payments and (2) the Plan's rights of subrogation, as provided for below.

### **Subrogation**

If a covered Employee or Dependent receives benefits from the Plan arising out of an injury or illness for which the Employee or Dependent (or the guardian or estate) has, may have, or asserts any claim or right to

## GENERAL PROVISIONS

recovery against a third party or parties, such benefit payments shall be made on the condition and with the understanding that this Plan shall be reimbursed. Such reimbursement shall be made by the covered Employee or Dependent (or the guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the covered Employee or Dependent (or the guardian or estate) from: (1) any policy or contract from any insurance company or carrier, and/or (2) any recovery from a third party, plan, or fund as a result of a judgment or settlement.

This Plan shall be subrogated to all claims, demands, actions, and rights of recovery against any entity including, but not limited to, third parties and insurance companies and carriers (including the covered Employee's or Dependent's insurer) to the fullest extent permitted by law in the appropriate jurisdiction. The amount of such subrogation shall equal the total amount paid under this Plan arising out of the injury or illness for which the covered Employee or Dependent (or the guardian or estate) has, may have, or asserts a cause of action. In addition, this Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights under this section.

The covered Employee or Dependent shall do nothing to prejudice this Plan's rights to reimbursement or subrogation, and shall cooperate fully with the Plan in asserting and protecting the Plan's subrogation rights. The covered Employee or Dependent shall execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect this Plan's subrogation rights.

The covered Employee or Dependent shall notify the Administrative Office, in writing, of whatever benefits are paid under this Plan that arise out of any injury or illness that provides or may provide the Plan subrogation rights under this section.

The Plan shall pay out of proceeds actually recovered a proportional share of any reasonable fee incurred by the covered Employee or Dependent for attorney services in collecting from such third party or parties. The Plan shall have sole discretion to determine the reasonableness of such fees.

Failure to comply with the requirements of this section by the covered Employee or Dependent (or the estate or guardian) may result in forfeiture of benefits under this Plan.

### **Coordination of Benefits With Other Plan Benefits**

This Plan has been designed to help you meet the cost of disease or injury. Since it is not intended that you receive greater benefits than the actual medical or dental expenses incurred, the amount of benefits payable under this Plan will take into account any coverage you have under other "plans," that is, the benefits under this Plan will be coordinated with the benefits of the other plans.

Specifically, in a calendar year, this Plan will always pay either its regular benefits in full, or a reduced amount which, when added to the benefits payable by the other plan or plans, will equal 100% of "allowable expenses:"

"Allowable expense" means any necessary, customary, and reasonable expense incurred while eligible for benefits under this Plan, part or all of which would be payable under any of the plans, but not any expenses contained in the list of exclusions.

"Plans" means any plan under which medical or dental benefits or services are provided by:

1. group insurance or any other arrangement of coverage for individuals in a group whether or not insured; or
2. Blue Cross, Blue Shield or any other pre-payment arrangement.

### **Which Plan Pays First?**

If both plans have a coordination of benefits provision, the plan that insures you as an Employee pays first. If you receive benefits as an Active Employee under one plan and as a Retiree or COBRA participant under another, the plan you have as an Active Employee pays first. If you are insured as an Employee under two (2) plans, the plan which has insured you longer is primary. If one plan does not have a coordination of benefits provision, that plan is always primary. If a Dependent child is covered under two plans, the plan of the parent whose birthday (month and day) is earlier in the year will pay its benefits first. If the parents of a Dependent

## GENERAL PROVISIONS

child are divorced or legally separated, the plan of the parent with custody of the child pays its benefits first. If the parent with custody remarries, the order of payment is as follows:

1. Natural parent with whom the child resides.
2. Stepparent with whom the child resides.
3. Natural parent not having custody of the child.

This order of payment can change pursuant to a Qualified Medical Child Support Order.

A spouse or Dependent who:

- a. is covered as an Employee, as well as a Dependent, will have any claims paid first as an Employee and any balance as a Dependent; and
- b. each Dependent child of such Employee and spouse will be considered a Dependent of both for payment of any claim up to 100% of covered charges.

### **Qualified Medical Child Support Order**

The Plan will comply with any medical child support order which meets the requirements of a Qualified Medical Child Support Order (QMCSO) under applicable Federal law as determined by the Plan Administrator. In order to be qualified, a medical child support order may not require the Plan to provide benefits to a person who is not otherwise eligible under the terms of the Plan, or to provide any form of benefit not otherwise provided under the terms of the Plan.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or a judgment from a state court or administrative body directing the company to cover a child under the plan. Federal law requires that a medical child support order meet certain form and content requirements in order to be qualified. You may request a copy of the written procedure for determining whether a medical child support order is qualified, free of charge, from the Plan Administrator.

### **Medicare Coordination of Benefits**

This Plan will pay benefits before Medicare in the following circumstances:

1. All claims for an Active Employee who is age 65 or older.
2. All claims for Dependents of an Active Employee over age 65.
3. The first thirty (30) months of treatment for end-stage renal disease received by any eligible person who is less than 65 years of age.

Medicare will be primary and this Plan secondary on claims for eligible Employees age 65 or older who do not fall within the above categories with coverage under the Active Plan. This would include retired Employees age 65 or older with extended coverage due to reserve accumulation or making allowable self-payments.

An Active Employee is an individual working in the industry having contributions remitted to the Plan or an individual available for work and on the out-of-work list of I.B.E.W. Local 332 and or an individual on the out-of-work list of I.B.E.W. Local 332 making self-payments for continued coverage. If you are over age 65 and an Active Employee or the spouse of an Active Employee, you may elect Medicare as your primary coverage. If Medicare is elected as primary, medical coverage under this Plan will cease.

The Plan will coordinate benefit payments and will observe assignment and benefit recovery procedures under any state plan of medical assistance approved under Title XIX of the Social Security Act in the manner and to the extent required by federal law.

### **List of Participating Facilities and Dentists**

The Blue Cross PPO includes an extensive network of hospitals, physicians and ancillary healthcare providers. The dental plan includes a network of participating dentists who have agreed by contract to reduced

## GENERAL PROVISIONS

rates and fee ceilings for both the dental plan and the patient. A list of participating providers is furnished automatically, free of charge, to you as a separate document.

### **Policies**

This benefit booklet describes the principal features of the Plan. The complete terms of the group insurance coverage for Life Insurance, Accidental Death & Dismemberment, Vision Service Plan, Kaiser Permanente, Health Net and PacifiCare are set forth in master group insurance policies issued by each of these providers.

## DISCLOSURE OF PROTECTED HEALTH INFORMATION

### **Disclosure**

The Plan and any Business Associate, as defined below, will disclose your Protected Health Information to the Board of Trustees only to permit the Board of Trustees to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. §§ 160-64). Any disclosure to and use by the Board of Trustees of your Protected Health Information will be subject to and consistent with this Section.

### **Restrictions on Use and Disclosure of Protected Health Information**

1. The Board of Trustees will not disclose your Protected Health Information, except as permitted or required by the Notice of Privacy and the Privacy Rule, as amended, or required by law.
2. The Board of Trustees will ensure that any agent, including any subcontractor, to who it provides your Protected Health Information agrees to the restrictions and conditions of the Plan Documents, including this Section, with respect to your Protected Health Information.
3. The Board of Trustees will not use or disclose your Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees.
4. The Board of Trustees will report to the Plan any use or disclosure of your Protected Health Information that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.
5. The Board of Trustees will make Protected Health Information available to the Plan Participant who is the subject of the information in accordance with 45 C.F.R. § 164.524.
6. The Board of Trustees will make your Protected Health Information available for amendment and will on notice amend your Protected Health Information, in accordance with 45 C.F.R. § 164.526.
7. The Board of Trustees will track disclosures it may make of your Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.
8. The Board of Trustees will make its internal practices, books, and records, relating to its use and disclosure of your Protected Health Information, available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 C.F.R. §§ 160-64.
9. The Board of Trustees will, if feasible, return or destroy all your Protected Health Information, in whatever form or medium (including any electronic medium under the Board of Trustees custody or control), received from the Plan, including all copies of any data or compilations derived from and allowing identification of any Participant who is the subject of the Protected Health Information, when your Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all your Protected Health Information, the Board of Trustees will limit the use or disclosure of any of your Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

### **Authorization**

Authorization is required for the use and disclosure of your Protected Health Information for purposes other than the permitted uses and disclosures specified in the Privacy Rule. When your authorization is needed, you will be asked to fill

out an authorization form. The signing of the form is completely voluntary, and once signed, may be revoked in writing at any time.

**Definitions**

Business Associate means a person or entity who provides certain functions, activities or services to the I.B.E.W. Local 332 Health and Welfare Plan involving the use and/or disclosure of Protected Health Information.

Protected Health Information means individually identifiable health information that is transmitted or maintained by electronic media or is transmitted or maintained in any other form.

# DEFINITION OF TERMS

## **Accidental Bodily Injury**

Physical damage to an individual which, independent of all other causes, is evidenced by a visible contusion or wound on the exterior of the body, except in the case of drowning or internal injuries revealed by autopsy.

## **Active Employee**

An active employee is an individual working in the industry having contributions remitted to the Plan or an individual available for work and on the out-of-work list of I.B.E.W. Local 332 or an individual on the out-of-work list of I.B.E.W. Local 332 making self-payments for continued coverage.

## **Beneficiary**

A person or entity named, on a form and in a manner approved by the Trustees, to receive benefits for loss of life.

## **Benefit Period**

Claims incurred for services rendered January through December of a calendar year. A benefit period is established, and begins, when you have incurred during a calendar year covered charges that exceed the deductible amount. All covered charges incurred during a benefit period are used in computing benefit payments. A Benefit Period for an individual ends on the earliest of the following:

1. The last day of the calendar year in which it was established; or
2. The day coverage provided under this Plan ends; or
3. The day the maximum benefit is paid.

## **Board of Trustees**

The individuals who govern the I.B.E.W. Local 332 Health and Welfare Plan.

## **Cosmetic Surgery**

The surgical alteration of tissue for the improvement of the covered individual's appearance rather than improvement or restoration of bodily function.

## **Covered Charges**

The Usual, Customary and Reasonable Charges or the negotiated rates payable to preferred providers incurred by an eligible person for the medically necessary treatment of conditions covered under the Plan.

## **Deductible**

The amount you pay before the Plan pays benefits. Charges that are not considered covered charges may not be used to satisfy the deductible.

## **Dependent**

Means:

1. An employee's spouse (if not legally separated from the employee). Coverage for the spouse ends on the date of divorce or legal separation unless COBRA coverage is elected.
2. An employee's unmarried child (including a stepchild or legally adopted child) from live birth or placement for adoption until the date the child attains age 19. Except that, the term dependent includes an employee's unmarried child who has attained age 19 while:

## DEFINITION OF TERMS

- a. the child is:
  - 1) mentally or physically unable to earn his/her own living and proof of incapacity is furnished to the Trustees within 31 days of the date his/her coverage would have ended due to age; and
  - 2) actually dependent on the employee for a majority of his/her support; and
  - 3) covered on the date just prior to the day his/her coverage would have ended due to age.
- b. the child:
  - 1) is enrolled in an accredited school as a full-time student as defined in the rules of such school; and
  - 2) has not attained age 25.

The Trustees may require evidence of dependent status such as a marriage license, birth certificate, student verification, etc.

### **Disability Period**

Means a period of time during which an individual is totally disabled. Under the following circumstances, successive periods of total disability due to the same or related causes will be considered one continuous period of total disability:

1. When an Employee has successive periods of total disability which are due to the same or related causes and which are not separated by two or more continuous weeks of active work with an employer; or
2. When a Dependent has successive periods of total disability which are due to the same or related causes and which are not separated by a period of three or more months during which the Dependent is free from total disability which stems from those same or similar causes.

### **Employee**

A person who is working for a contributing Employer or who is on the out-of-work list of an I.B.E.W. Local Union.

### **Employer**

Any employer with a collective bargaining agreement requiring contributions to the Trust, and any employer making contributions under a written participation agreement approved by the Trustees.

### **Emergency Care**

"Emergency Care" is defined as the sudden onset of a medical condition accompanied by acute symptoms of sufficient severity (including severe pain) that could possibly result in the following if immediate medical attention is not provided:

1. Permanently placing the person's health in jeopardy;
2. Causing other serious medical problems;
3. Causing serious impairment to bodily functions; or
4. Causing serious and permanent dysfunction of any bodily organ or part; and
5. Hospital services which are certified as an "EMERGENCY" by Utilization Review ("UR").

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### **Experimental or Investigational Services**

1. A service is experimental or investigational for a patient's condition if any of the following statements apply to it as of the time the service is or will be provided to the patient.  
  
The service:
  - a. cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or
  - b. is the subject of a current new drug or new devices application on file with the FDA; or
  - c. is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service; or
  - d. is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy as among its objectives; or
  - e. is subject to the approval or review of an Institutional Review Board ("IRB") or other body that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
  - f. as to the service, the prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that (1) use of the service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity, or efficacy of the service.
2. In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon:
  - a. the patient's medical records;
  - b. the written protocol(s) or other document(s) pursuant to which the service has been or will be provided;
  - c. any consent document(s) the patient or patient's representative has executed or will be asked to execute, to receive the service;
  - d. the files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;
  - e. the published authoritative medical or scientific literature regarding the service, as applied to the patient's illness or injury; and
  - f. regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.
3. If two or more services are part of the same plan of treatment or diagnosis, all of the services are excluded if one of the services is experimental or investigational.

### **Hospital**

A facility which:

1. Is licensed (if required) as a hospital;
2. Is open at all times;
3. Is operated mainly to diagnose and treat illnesses on an inpatient basis;

## DEFINITION OF TERMS

4. Has a staff of one or more doctors on call at all times;
5. Has 24-hour nursing services by Registered Nurses;
6. Is not mainly a skilled nursing facility, clinic, nursing home, rest home, convalescence home or like place; and
7. Has organized facilities for major surgery.

### **Illness**

Means:

1. A disorder or disease of the body or mind;
2. An accidental bodily injury; or
3. Pregnancy.

All illnesses due to the same cause, or to a related cause, will be deemed to be one illness.

### **Individual**

An employee or one of his/her Dependents. A covered individual means an individual covered under this Plan.

### **Insurance Company**

The Principal Life Insurance Company.

### **Medical Coverage**

Benefits in this Plan other than Life Insurance, Accidental Death & Dismemberment Benefit, Weekly Income Benefit, Dental, and Vision Benefit.

### **Medical Necessity**

Those services and supplies required for diagnosis and treatment of an illness, injury, mental illness or chemical dependency that, in the judgment of the Board of Trustees:

1. Are consistent with the symptoms or diagnosis and treatment of your condition;
2. Are appropriate with regard to standards of good medical practice;
3. Are not primarily for the convenience of you or a provider of services or supplies;
4. Cannot be left out without adversely affecting your condition; and
5. Are the least costly of the alternative supplies or level of service that can be safely provided to you. This means, for example, that care rendered in a hospital inpatient setting or by a nurse in your home is not medically necessary if it could be provided in a less expensive setting, such as a skilled nursing facility without harm to you.

The fact that a provider may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply medically necessary.

### **Medicare**

Medical benefits provided by Title XVIII of the Federal Social Security Act.

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### **Mental Illness**

Conditions and diseases listed in the most recent edition of the Internal Classification of Diseases (ICD) as psychoses, neurotic disorders or personality diseases; other non-psychotic mental disorders listed in the ICD as determined by the Board of Trustees. Mental illness does not include the treatment of Chemical Dependency.

### **Month**

A period starting at 12:01 a.m. on any day in a given Calendar Month and ending at 12:01 a.m. on that same-numbered day in the next Calendar Month. If that next Calendar Month does not have a same-numbered day, the month will end at 11:59 p.m. of the last day of that Calendar Month (Examples: 12:01 a.m. of May 14 up to 12:01 a.m. of June 14; 12:01 a.m. of May 31 through 11:59 p.m. of June 30).

### **One Continuous Period of Disability.**

A period of time during which you are totally disabled. Under the following circumstances, successive periods of total disability due to the same or related causes will be considered one continuous period of total disability:

1. When you have successive periods of total disability that are due to the same or related causes and which are not separated by two or more continuous weeks after being released for active employment by your physician; or
2. When a Dependent has successive periods of total disability that are due to the same or related causes which are not separated by a period of three or more months during which the Dependent is free from total disability that stems from those same or similar causes.

### **Owner**

An "owner" is:

1. a sole proprietor or partner if the business is not incorporated;
2. a shareholder with 10% or more of the stock if the business is incorporated; or
3. the spouse of a person described in 1 or 2 above.

Exceptions: a shareholder or the spouse of an owner may be reclassified as a bargaining unit employee by providing evidence satisfactory to both I.B.E.W. Local 332 and NECA that his/her duties are limited to bargaining unit work and that another person actively operates and controls the business.

### **Plan Administrator**

The Board of Trustees. The Board of Trustees has delegated responsibility for the daily administration of the Plan to United Administrative Services, whose address is 1120 S. Bascom Avenue, San Jose, CA 95128.

### **Preferred Provider**

Any physician, hospital, medical clinic or facility which belongs to the Preferred Provider Organization network recognized by the Plan as a Preferred Provider.

### **Provider**

1. A licensed Medical Doctor (M.D.).
2. A licensed Doctor of Osteopathy (D.O.).
3. A Chiropractic physician (D.C.) (under certain limited conditions).
4. A Doctor of Medical Dentistry (D.M.D.).

## DEFINITION OF TERMS

5. A Doctor of Dental Surgery (D.D.S.).
6. Denturist (under certain conditions).
7. Optometrist (O.D.).
8. A Doctor of Podiatric Medicine (D.P.M.).
9. Licensed Clinical Psychologist (PhD).
10. Clinical Social Worker who:
  - a. has a master's or doctoral degree in social work;
  - b. has at least two years of clinical social work practice;
  - c. is certified by the Academy of Certified Social Workers (ACSW); and
  - d. in states requiring license, certification, or registration, is licensed, certified, or registered as a social worker where the services are rendered (LCSW or RCSW).
11. Master of Science Arts, Certified Competent Clinician Audiology.
12. A Nurse Midwife, who is:
  - a. a Certified Nurse Practitioner;
  - b. certified by the American College of Nurse Midwives;
  - c. under the supervision of a qualified physician or hospital; and
  - d. licensed as a Nurse Midwife by the state in which care is rendered (if that state's laws license Midwives).
13. A registered Physical Therapist who is licensed as a Physical Therapist by the state in which care is rendered (if that state's laws license Physical Therapists), for rehabilitative services rendered upon the written referral of a physician.
14. A Speech Therapist who:
  - a. has a master's degree in speech pathology;
  - b. has completed an internship; and
  - c. is licensed as a Speech Therapist by the state in which services are performed (if that state's laws license Speech Therapists).
15. A legally qualified Physician's Assistant who is certified by the National Commission on Certification of Physician's Assistants; or is a certified graduate of an approved training course which is accredited by the American Medical Association's Committee on Allied Health Education; and works for a clinic or for a licensed physician who is an M.D. or D.O. This does not apply if applicable law does not allow it.
16. Nurse Practitioner (Certified).

### **Room and Board Charges**

Charges made by a hospital or skilled nursing facility for the room, meals, and routine nursing services for covered individuals confined as bed patients. Room and board is limited to the hospital's prevailing charge for a semiprivate room.

## DEFINITION OF TERMS

### **Skilled Nursing Facility**

A facility qualified as such under Medicare.

### **Special Charges**

Those charges made by the hospital for other than room and board. Special charges include, but are not limited to, charges made by a legally qualified physician for professional services in connection with radiology and pathology. Anesthesiology is included unless otherwise provided under the surgical benefits.

### **Speech Therapist**

Someone who:

1. Has a master's degree in speech pathology; and
2. Has completed an internship; and
3. Is licensed by the state in which he/she performs his/her services, if that state requires licensing.

### **Summary of Benefits**

That part of this Plan outlining the benefits.

### **Total Disability**

You will be deemed to have a total disability under the following circumstances:

1. If you are claiming benefits under this Plan, total disability is defined as your inability to work because of illness or injury in your normal job;
2. If a Dependent is claiming benefits under this Plan, total disability is defined as the inability of the Dependent to do the substantial and material duties of a person in similar circumstances who is in good health.

### **Usual, Customary and Reasonable Charges**

Charges normally made by the person, group or other entity rendering or furnishing the services, treatments or materials that fall within the range of charges made by others rendering or furnishing such services, treatments or materials to persons of similar income or net worth within the area in which you normally reside for illnesses or injuries of comparable severity and nature to the illness or injury being treated. As to any particular service, treatment or material, the term "area" means a country or such representative cross section of persons, groups or other entities rendering or furnishing such services, treatment or material to persons of similar income or net worth. If you receive a covered service that costs more than this usual, customary and reasonable charge, the Plan will pay benefits based only on the amount considered usual, customary and reasonable.

### **You or Your**

The Employee and/or Dependent(s).

# I.B.E.W. LOCAL 332 HEALTH AND WELFARE PLAN

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