

**RIVERSIDE COUNTY ELECTRICAL
HEALTH AND WELFARE TRUST FUND**

ACTIVE EMPLOYEES PLAN

JULY 1, 2008

Riverside County Electrical Health & Welfare Trust Fund

To all Eligible Active Employees:

We are pleased to present you with this new booklet, dated July 1, 2008. It replaces all previously issued benefits material. If you are approaching retirement, you should request a copy of the benefit booklet for Retired Employees to become familiar with the eligibility requirements and benefits.

This Summary Plan Description (SPD) contains information on how you and your family members become eligible for benefits, your benefit choices and what you should do when loss of eligibility occurs. It also includes important information about your rights to privacy of protected information and your rights under ERISA.

If you enroll in the Indemnity Self-Funded medical plan, this booklet tells you about the plan, excluded benefits, limitations that apply to benefits, how to file a claim, and the steps you should take if you wish to appeal a claim that has been denied in whole or in part.

If you select coverage under one of the prepaid insured medical or dental plans, the details of the plans (including plan limitations, exclusions, how to file a claim or appeal a claim that has been denied) will be provided in separate booklets. This booklet gives you information about becoming eligible, your rights to continued coverage when eligibility is lost and other facts about the Trust.

Some of the health care coverage provided by the Plan is self-funded and other benefits are fully insured with various carriers. Regardless of the funding method, the success of the Plan is dependent upon the wise choices you make and your use of health care services. With medical costs always on the rise, cost conscious use of medical care will better assure the ability of the Plan to continue to offer quality health care coverage to eligible participants and their families.

You should retain this booklet for reference purposes since the payment of benefits will be based on the latest information issued to you for insertion in this booklet.

Sincerely,

Board of Trustees

SPECIAL NOTICE

THIS PLAN BOOKLET IS INTENDED TO BE A COMPREHENSIVE EXPLANATION OF THE HEALTH CARE COVERAGE OFFERED BY THE PLAN AND SHOULD ANSWER MOST OF YOUR COVERAGE QUESTIONS. HOWEVER, THE ACTUAL GOVERNING PROVISIONS MAY BE CONTAINED IN OTHER CONTRACTS WITH INSURANCE CARRIERS AND OTHER PROVIDERS.

ALL QUESTIONS WITH RESPECT TO PLAN PARTICIPATION, ELIGIBILITY FOR BENEFITS, OR THE NATURE AND AMOUNT OF BENEFITS, AND ANY MATTER OF THE HEALTH AND WELFARE PLAN OR PLAN ADMINISTRATION SHOULD BE REFERRED TO THE ADMINISTRATIVE OFFICE OF THE PLAN. NO REPRESENTATIONS MADE TO A PARTICIPANT, PHYSICIAN OR OTHER PROVIDER OF MEDICAL SERVICES CONCERNING ELIGIBILITY, ENTITLEMENT TO BENEFITS OR AMOUNT OF BENEFITS PAYABLE ARE BINDING ON THE TRUST FUND UNLESS THE REPRESENTATION IS IN WRITING AND MADE BY THE BOARD OF TRUSTEES. THE ONLY PARTIES AUTHORIZED TO ANSWER ANY QUESTIONS CONCERNING THE ACTIVE EMPLOYEES' HEALTH AND WELFARE FUND ARE THE TRUSTEES AND THE ADMINISTRATIVE OFFICE. NO PARTICIPATING EMPLOYER ASSOCIATION OR LABOR ORGANIZATION, OR ANY INDIVIDUAL EMPLOYED THEREBY, HAS ANY SUCH AUTHORITY.

The terms "he", "him" or "his" are interchangeable and have the same meaning as "she", "her" and "hers" as used in this booklet.

Nothing in this SPD is meant to interpret or extend or change in any way the provisions expressed in the Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant it.

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PLAN BOOKLET INTRODUCTION

The Board of Trustees of the Riverside County Electrical Health and Welfare Trust Fund is pleased to be able to offer the health care coverage to eligible Active Plan participants. This Plan Booklet is a comprehensive summary of the benefits that are available to eligible participants as of January 1, 2008.

You should pay particular attention to the following information relating to the Indemnity Medical Plan:

- The medical coverage under the Indemnity Medical Plan includes a Preferred Provider Option (“PPO”) network, Beech Street. If you use providers who participate in the Beech Street PPO, you may be able to receive benefits at enhanced levels as these providers have agreed to discount their fees. The Indemnity Medical Plan is self-insured; Beech Street does not insure the program. (Refer to the Schedule of Medical Benefits for further information)
- The Indemnity Medical plan also includes a Utilization Review Program. To ensure that you receive the maximum Plan benefits, make certain that you have read and understand the requirements of this program that is administered by Alicare Medical Management (Refer to page 30 for more information)
- Your ID card has the telephone number for the Administrative Office. It also contains other information to assist you in complying with the requirements of the Plan. The Administrative Office will provide you with an ID card if you are a new member or your ID card is lost or stolen.
- Claims must be filed within one year of the date expenses are incurred or they will not be covered. Beech Street handles all Hospital claims. The Administrative Office handles all other claims. Review the section entitled “Benefit Claims and Appeals Procedures” on page 80 so that your claims are sent to the correct party.

If you have questions about your eligibility, benefits or claims, you may contact the Administrative Office.

CHOICE OF MEDICAL AND DENTAL PLANS & OPEN ENROLLMENT

Medical Plan Choices for Active Employees and Dependents

The medical benefit plan options available through the Trust are described below:

- 1. A prepaid health plan provided through Aetna.** You and your Dependents must live or work within 30 miles of an Aetna participating medical group in order to enroll in this plan. If you enroll in this option, you and your eligible Dependents will be covered under the Aetna plan for all Hospital, prescription drugs, medical services and supplies if you use the Aetna plan providers, subject to certain copayments.
- 2. A prepaid health plan provided through Kaiser.** In order to enroll in this plan, you must live or work within the Kaiser zip code enrollment area. If you enroll in this option, you and your eligible Dependents will be covered under the Kaiser Plan for all Hospital, prescription drugs, medical services and supplies if you use Kaiser facilities, subject to certain copayments. .
- 3. An Indemnity Medical Benefits.** Under the Indemnity Medical plan, you may use the Doctor of your choice. This plan contains a Preferred Provider Option (PPO) which allows you to save out-of-pocket expense by using Hospitals and professionals which have contracted rates through Beech Street. If you enroll in this plan, all of your Hospital, prescription drugs, medical services and supplies will be based on the benefits described in this booklet.

A complete description of the medical benefits provided directly by the Fund is contained in this booklet. Brochures are available from the Administrative Office at no charge that will provide you with a description of benefits provided by Aetna and Kaiser.

Dental Plan Choices for Active Employees

- 1. An insured Delta Dental Plan** where you can use any dental provider for services. This plan contains a DPO dental network option that enables you to save money by using one of the contracting dentists. If you enroll in this plan you will have greater out-of-pocket expense.
- 2. A prepaid dental plan through Delta PMI** that requires you to receive all of your dental care through PMI dentists. This plan results in lower out-of-pocket expense.

A brief description of the dental benefits provided under the Delta DPO and PMI dental plans is contained in this booklet. Brochures are available from the Administrative Office at no charge that will provide you with more details of benefits provided under the Delta DPO plan and the Delta PMI plan. You must select a dental plan and complete the necessary application in order to be covered.

Other Benefits for Active Employees

Regardless of the medical or dental plan you select, you will also be covered by Life Insurance and Accidental Death and Dismemberment benefits as well as Vision benefits.

Open Enrollment

The Plan has a “Rolling-12” enrollment provision. A participant will have the option to select and enroll in a different medical and/or dental plan at any time during the year, providing the participant has been eligible and enrolled under their current plan for at least twelve (12) months.

To exercise this option the participant can contact the administrative office to confirm they have been enrolled in their current plan for a minimum of twelve (12) months. If so, enrollment materials for the provider they are interested in enrolling in can be requested. Enrollment changes will be effective the first of the month following submission of the required enrollment application, provided it is received by the Trust office by the 20th of the month. If received after the 20th, the effective date of the enrollment change would be the first of the second month following receipt of the enrollment materials.

Note for dependents: Except as required under HIPAA, dependents can be enrolled under the “Rolling-12” enrollment provision during a one-month window each calendar year.

If you move out of your HMO service area, or if the HMO discontinues operations for financial or other reasons and you will remain eligible for coverage in the Plan, or if the Trustees terminate their agreement with the HMO, you may elect coverage in another HMO or in the indemnity medical plan. A written request for change must be submitted to the Administrative Office within 61 days of the residence change or discontinuance. Any such coverage under the Plan will become effective on the later of the first of the month following the month in which:

- the Active Employee makes the written request; or
- there is a change in residence or HMO.

If you fail to request the change within 61 days, you and your eligible Dependent(s) will be enrolled in the Indemnity Medical Plan. If you do not enroll in a dental plan, you will not be covered.

Schedule of Benefits for Active Employees and Dependents			
Benefit Description	Member Copayments		
	Indemnity Plan	Kaiser	Aetna
Life Insurance			
Active – Employee	\$11,000	\$11,000	\$11,000
– Spouse	\$5,000	\$5,000	\$5,000
– Child	Up to \$1,000	Up to \$1,000	Up to \$1,000
Accidental Death & Dismemberment (Employee only)	\$11,000	\$11,000	\$11,000
Medical Benefits			
Calendar Year Deductible			
PPO			
Per person	\$200	None	None
Per family	\$400	None	None
Non-PPO			
Per person	\$250	None	None
Per family	\$500	None	None
Calendar Year Out-of-Pocket Maximum			
PPO	\$2,500 per person	\$1,500 per person;	\$1,500 per person;
Non-PPO	\$10,000 per person	\$3,000 family	\$3,000 family
Lifetime maximum	\$1,000,000	None	None
Hospital – Inpatient (Room & Board/Miscellaneous)			
PPO	80% of contract rate*	No Charge	No Charge
Non-PPO	80% of UCR*	No Charge	No Charge
Surgical and Anesthetist			
PPO	80% of contract rate*	No Charge	No Charge
Non-PPO	80% of UCR*	No Charge	No Charge
Ambulance	80%	No Charge	No Charge
Maternity Benefits – Office Visits			
PPO	\$15 copay	\$5 Copay	Only \$15 Copay to confirm pregnancy
Non-PPO	80% of UCR*		
Family Planning			
PPO	\$15 copay	\$15 Copay	\$15 Copay
Non-PPO	80% of UCR*		
Well Child Care (to age 2)			
PPO	\$15 copay	\$5 Copay	\$15 Copay
Non-PPO	80% of UCR*		
Physical Exam			
To age 18:			
PPO	\$15 copay	\$5 Copay	\$15 Copay
Non-PPO	Not Covered		
Age 18 and older			
PPO	80% of contract rate*; \$300 max per calendar year	\$5 Copay	\$15 Copay
Non-PPO	Not Covered		

*Payments based on Beech Street negotiated fee schedule for PPO providers and UCR for non-PPO providers. . Payments to some non-contract providers are payable at 100% of UCR. See Indemnity Plan Medical Benefits for details.

Schedule of Benefits for Active Employees and Dependents (Continued)			
Benefit Description	Plan Benefit	Member Copayments	
	Indemnity Plan	Kaiser	Aetna
Diagnostic X-ray and Laboratory PPO Non-PPO	80% of contract rate* 80% of UCR*	No Charge	\$15 Copay
Physician Visits – office PPO Non-PPO	\$15 Copay 80% of UCR*	No Charge	\$15 Copay
Physical Therapy PPO Non-PPO	80% of contract rate* 80% of UCR*	\$15 Copay	\$15 Copay
Acupuncture PPO Non-PPO	80% of contract rate* 80% of UCR*	\$15 Copay	\$15 Copay
Chiropractic PPO Non-PPO	80% of contract rate* ** 80% of UCR* ** **Max. 26 visits and \$1,500/yr; \$10,000 lifetime combined benefits	Not Covered	25% discount available
Durable Medical Equipment PPO Non-PPO	80% of contract rate* 80% of UCR*	No Charge	No Charge
Home Health Care PPO Non-PPO	80% of contract rate* 80% of UCR*	No Charge – 100 2-hour visits/yr	No Charge
Extended Care Facility/Skilled Nursing Facility PPO Non-PPO	80% of contract rate* 80% of UCR*	No Charge – 100 days per calendar year	No Charge in lieu of hospitalization
Mental Health Inpatient PPO Non-PPO	80% of contract rate* ** 50% of UCR* ** Combined 15 days/year	No Charge – 30 days per calendar year	No Charge – 30 days per calendar year
Outpatient PPO Non-PPO	50% of contract rate* ** 50% of UCR* ** Combines 20 visits/year	\$7 group/\$15 individual Copay; 20 visits/calendar year Day limits do not apply to severe mental illness	\$25 Copay 20 visits/calendar yr

*Payments based on Beech Street negotiated fee schedule for PPO providers and Usual, Customary & Reasonable for non-PPO providers. Payments to some non-contract providers are payable at 100% of UCR. See Indemnity Plan Medical Benefits for details.

**Requires preauthorization

Schedule of Benefits for Active Employees and Dependents (Continued)			
Benefit Description	Plan Benefit	Member Copayments	
	Indemnity Plan	Kaiser	Aetna
Substance Abuse Inpatient PPO	50% of contract rate* **	No Charge	No Charge – 30 days per calendar year
Non-PPO	50% of UCR* ** 1 course of treatment Combined 5 days/year	Transitional Residential – \$100 Copay/admission; 60 days/calendar yr; 120 days in 5 years	Detox – no charge
Outpatient PPO	50% of contract rate* **	\$15 individual; \$5 group	\$15 Copay; 20 visits/calendar year
Non-PPO	50% of UCR* ** Combined 25 visits/year		
Hearing Aids	Not Covered	Not Covered	Not Covered
Emergency Room PPO	80% of contract rate*	\$15 Copay; waived if admitted	\$50 Copay
Non-PPO	80% of UCR*		
Prescription Drugs***	Provided through Express Scripts		
Retail (30-day supply)			
Generic	\$10	\$10	\$10
Brand formulary	\$20	\$20	\$20
Non-formulary	\$30	\$20	\$35
Mail Order (up to 100-day supply)			
Generic	\$20	\$10	\$20
Brand formulary	\$40	\$20	\$40
Non-formulary	\$60	\$20	\$70

*Payments based on Beech Street negotiated fee schedule for PPO providers and Usual, Customary & Reasonable for non-PPO providers. Payments to some non-contract providers are payable at 100% of URC. See Indemnity Plan Medical Benefits for details.

**Requires preauthorization.

***Once the annual out-of-pocket maximum is reached, members are reimbursed for copayments for the balance of the calendar year.
Note: The Trust will pay 100% of URC allowance for ancillary services provided by a Non-Contract Provider while a participant is receiving services in a PPO contracted hospital or PPO out-patient surgical facility, while under the care of a PPO physician. Ancillary services include x-ray, laboratory, anesthesia providers and emergency room physicians for which the patient does not have a choice of provider.

Schedule of Benefits for Active Employees and Dependents (Continued)			
Benefit Description	Member Copayments		
Vision Care (through Vision Service Plan) Deductible	\$20 copay		
Frequency Exams	once every 12 months		
Lenses	once every 24 months		
Frames	once every 24 months		
Dental Benefits Delta Preferred Option PPO)	DPO	Non-DPO Dentist	Non-Delta Dentist
Calendar Year Deductible	\$50/person \$150/family	\$100/person; \$300/family	\$100/person; \$300/family
Calendar Year Maximum	\$2,000	\$2,000	\$2,000
Diagnostic and Preventive Basic Benefits	100%*	100%*	90%
Crowns, Jackets and Other	80%	80%	70%
Cast Restorations, Prosthodontics	80%	80%	70%
Orthodontia	50% up to \$1,500 lifetime	50% up to \$1,500 lifetime	50% up to \$1,500 lifetime
Delta PMI			
Calendar Year Deductible	None		
Calendar Year Maximum	None		
Diagnostic and Preventive Basic Benefits	No Charge		
Crowns, Jackets and Other	Some copayments		
Cast Restorations, Prosthodontics	No Charge for most procedures; some copays for bridge work		
Orthodontia	\$1,600 – child; \$1,800 – adult plus retention charge		

*Not subject to Deductible

ELIGIBILITY RULES FOR ACTIVE EMPLOYEES

Who Is Eligible for Benefits?

To be eligible for Plan coverage as an Active Employee you must be:

- A bargaining unit employee who is covered by a Collective Bargaining Agreement between a Participating Employer and the International Brotherhood of Electrical Workers Local 440 (IBEW Local 440) that requires contributions to this Trust Fund; or
- A full-time employee of IBEW Local 440, or any other participating local if approved by the Trustees of this Trust Fund; or
- A non-bargaining unit employee whose Participating Employer has signed a Participation Agreement with the Trustees of the Riverside County Electrical Health Plan under the terms and conditions established by the Trustees.

Eligibility for Bargaining Unit Employees

Initial Eligibility

You will become eligible as an Active Employee on the first day of the second calendar month following the month in which you completed a minimum of 260 hours of work for one or more Participating Employers within a consecutive 6-month period. Only those hours for which the required contributions were made in accordance with the terms of your Collective Bargaining Agreement will be counted toward your eligibility. In the absence of a signed Collective Bargaining Agreement, a Letter of Assent to the terms of the Collective Bargaining Agreement may be acceptable. *Different initial eligibility rules apply to employees of newly organized contractors (see below).*

For example, if you complete 260 hours of work from January through March 30, your eligibility will begin May 1. The month before your eligibility begins is called a “lag month”. This month is necessary because employers make contributions the month after the work is performed. The following is an example of the work month, lag month and eligibility month:

Month in which 260 Hours were Completed	Lag Month	Eligibility Month
April	May	June
May	June	July

Any hours worked in excess of the number of hours required for initial eligibility are maintained in an Hour Bank Reserve on your behalf.

In the event you fail to establish eligibility within the required 6-month period, the hours worked in the first month will be deleted. Your new 6-month period will begin with the first day of the next month. For example, if your first month of work was January but by the end of June you had not worked 260 hours, your new 6-month accumulation period would be from February through July of the following year. (This is referred to as a “rolling 6-month eligibility period”)

Initial Eligibility for Employees of Newly Organized Contractors

Employees employed by an employer that has signed a letter of assent to the Collective Bargaining Agreement may become eligible for benefits under this Trust Fund if:

- the employee has have been working on a full-time basis for a minimum of 30 continuous days for the employer and has been covered for group medical coverage during the 30-day period immediately prior to the date of the signed letter of assent; and
- the employee has contributions made to this Trust Fund in accordance with the terms of the collective bargaining agreement following the date of the signed letter of assent.

If the employee satisfies these rules for eligibility, the employee will be granted an initial Hour Bank Reserve of 260 hours in order to gain eligibility. In order to offset this initial Hour Bank Reserve, the first 260 hours of an eligible Employee’s hours worked in excess of 130 hours per month will not be credited to the Employee’s Hour Bank Reserve.

Example: Letter of Assent is signed by the employee’s employer for an effective date of June 1. The 260 hours credited to the Employee’s Hour Bank Reserve will buy benefits for June and July. In order to qualify for coverage in August, the employee must have worked a minimum of 130 hours in the month of June.

Hour Bank Reserve

Once you have satisfied the initial eligibility hours requirement, any hours you work for which contributions are received will be credited to an Hour Bank on your behalf. Your Hour Bank may never contain more than 750 hours after deduction of 130 hours which is required for one month of eligibility. With some exceptions, you may use the hours in your Hour Bank for continuing eligibility if the hours you work are insufficient for continuing eligibility. The following exceptions apply:

- If you have less than 130 hours remaining in your Hour Bank and you fail to re-qualify for coverage through hours worked within 8 consecutive months, your

residual hours will be forfeited and you will have to again satisfy the initial eligibility requirements.

- If you knowingly work for an employer that ceases to be a Participating Employer who is signatory to a Collective Bargaining Agreement requiring contributions to this Trust Fund, any hours remaining in your Hour Bank will be forfeited and your eligibility will cease.
- If you work for a non-signatory employer in the trade, craft or industry covered under the IBEW Local 440-NECA Collective Bargaining Agreement, any hours remaining in your Hour Bank will be forfeited and your eligibility will cease.

Option to Freeze Hour Bank Reserve

One of the features of the Hour Bank is the option to freeze your Hour Bank. If your Hour Bank contains a minimum of 130 hours when you leave Covered Employment with a Participating Employer of this Trust Fund, you may:

- Run out your Hour Bank Reserve in order to extend your benefits; or
- Within 30-days of the date you are leaving Covered Employment with a Participating Employer, you may provide written notice to the Administrative Office that you want to freeze your Hour Bank for a period of up to 12-months. The following rules will apply:
 - Freezing of your Hour Bank will become effective on the first day of the month following the date of your notice, if the Administrative Office receives the notice by the 15th day of that month; or on the first day of the second month if notice is received after the 15th day of the month.
 - You must re-enter Covered Employment with a Participating Employer within 12 months of the date you served notice to freeze your Hour Bank and you must notify the Administrative Office of your desire to unfreeze your Hour Bank within 30 days of the date you returned to Covered Employment. The term “Covered Employment” as used herein means the first day of work for which contributions are made or should have been made on your behalf.
 - Unfrozen hours of less than 240 will result in coverage beginning on the first day of the month following the month you have worked 130 hours for which contributions are required to be made to the Trust Fund.
 - Unfrozen hours of 260 or more will result in coverage becoming effective on the first day of the month following the date you return to Covered Employment.

Effective Date of Coverage and Available Benefits

Coverage for you and your eligible Dependents begins on the first day of the second month following the month you have satisfied the initial eligibility requirements. *Everyone is required to enroll for coverage if selecting coverage under an HMO plan by completing enrollment forms and submitting them to the Administrative Office. If you have not received enrollment forms by the time you have completed 150 hours of Covered Employment, you should contact the Administrative Office to request your enrollment package. You must select and complete a dental application in order to be enrolled and receive dental benefits.*

If you acquire a spouse or child after you become eligible, coverage will begin for the new Dependent on the date acquired if you are enrolled in the Indemnity Medical plan. If you are enrolled in a prepaid medical plan, coverage for a new spouse will begin on the first day of the month following your marriage provided the spouse is enrolled within 30 days, or on the date of birth for a new born child provided the child is enrolled within 30 days. *All Dependents must be enrolled within 30 days of the date acquired if you are enrolled in a prepaid plan. Failure to enroll during this period will result in no coverage for the Dependent until the next Open Enrollment period. A copy of your marriage certificate for your spouse and a copy of the birth certificate for your children must be submitted with your enrollment form.*

Benefits for Active Employees and Dependents include life insurance, (accidental death and dismemberment benefits for Employees only), medical, prescription drugs, dental and vision benefits.

Continuing Eligibility

After you have satisfied the hours requirement for initial eligibility, you will continue to be eligible for each future month provided your Hour Bank contains a minimum of 130 hours (the number of hours required for one month of coverage).

Self-Payment for Coverage

Once you have established eligibility for benefits, if your Hour Bank contains less than the 130 hours needed for eligibility, you may continue your coverage by making self-payment in an amount established by the Board of Trustees provided you are a member of Local 440; members of a different local who have not registered on ERTS for reciprocity are not included. Your self-payment will provide coverage for all of your benefits for you and your Dependents. To be eligible for self-payment, you must be immediately available for work – except if: (1) you are disabled and unable to work and you present a doctor's certificate to that effect or (2) you obtain written approval from the Board of Trustees to make direct payments during an extended leave of absence.

A self-pay notice will be mailed to you if you are eligible in the current month and have less than 130 hours in your Reserve Bank. You must make your self-payment by the 25th

day of the month prior to the month of coverage. The amount of the self-payment is the same for everyone, regardless of the employee's Hour Bank balance. Self-payment is permitted for a maximum of 9 consecutive months. If you fail to make a timely self-payment your right to continued coverage will be lost.

If you have self-paid for coverage for the maximum 9-month period and you still have not regained eligibility, any residual hours remaining in your Hour Bank will be forfeited. You and your Dependents will have the option of continuing coverage under the terms of COBRA (refer to page 20 for details). Any period of continued coverage through self-payment will count towards the maximum period of COBRA coverage.

Coverage During Temporary Disability

If you become temporarily disabled while you are eligible through hours worked (excluding eligibility resulting from COBRA or Self-Payments) as an Active Employee, coverage may be continued without self-payment for you and your Dependents during the period of disability. The following rules apply:

1. To be considered "temporarily disabled" and eligible for coverage:
 - You must be unable to perform the duties of your regular occupation under the IBEW collective bargaining agreement; and
 - Your disability must continue for 30 or more days; and
 - You must provide a Disability Certification completed by your physician and a copy of your Workers Compensation or State Disability Insurance (SDI) payments.
2. You must have exhausted your Hour Bank reserve.
3. If you have satisfied the above requirements, the Board will approve your request for extension of coverage during your disability.

Coverage may be continued without self-payment for you and your Dependents until the earliest of: the date you are no longer disabled; or, 12 consecutive months. Exception: If you recover from your disability and register for immediate work, your disability extension may be continued for up to an additional 3 months to allow you to qualify for coverage based on hours worked. However, this extension will only be granted if you have at least 3 or more months of disability extension available. At the end of the disability or the 12-month period, you may continue coverage through self-payment. In no event, however, will more than 24 months of coverage be available through a combination of self-payment and disability extension. Any continued coverage under the self-pay provisions will count against the maximum period of coverage under COBRA.

For purposes of applying the 12-month limitation, successive disabilities will be treated as a single period of disability unless the disabilities were caused by different and/or unrelated causes or (2) the disabilities were due to a related cause and are separated by at least 3 months of continuous active employment with a participating employer.

Reciprocity

This Trust Fund is signatory to the IBEW International Reciprocity Agreement. You may have contributions for hours worked in the jurisdiction of another trust fund that is signatory to the International Reciprocity Agreement sent to this Trust Fund for a period not to exceed 3 months prior to your registration on the Electronic Reciprocity Transfer System (ERTS). Subsequent contributions following your ERTS registration will continue until you cease reciprocity contributions by again registering on ERTS. The other trust fund where you were working will pay reciprocal contributions on your behalf to this Trust Fund (your home Trust) at the lesser of the hourly contribution rate in effective under that trust fund or the contribution rate of this Trust Fund multiplied by the hours you worked.

Eligibility for Non-Bargaining Unit Employees

Initial Eligibility

You will become eligible as an Active Employee on the first day of the second calendar month following the receipt of three months of contributions made on your behalf. Only those hours for which the required contributions were made in accordance with the Employer’s Participation Agreement will be counted toward your eligibility

For example, if you complete 300 hours of work from January through March 20, your eligibility will begin May 1. The month before your eligibility begins is called a “lag month”. This month is necessary because employers make contributions the month after the work is performed. The following is an example of the work month, lag month and eligibility month:

Month in which 300 Hours were Completed	Lag Month	Eligibility Month
April	May	June
May	June	July

In the event you fail to establish eligibility within the required 12-month period, the hours worked in the first month will be deleted. Your new 12-month period will begin with the first day of the next month. For example, if your first month of work was January but by the end of December you had not worked 300 hours, your new 12-month accumulation period would be from February through January of the following year. (This is referred to as a “rolling 12-month eligibility period”)

Effective Date of Coverage and Available Benefits

Coverage for you and your eligible Dependents begins on the first day of the second month following the month you have satisfied the initial eligibility requirements. *Everyone is required to enroll for coverage by completing enrollment forms and submitting them to the Administrative Office. If you have not received enrollment forms by the time you have completed 150 hours of Covered Employment, you should contact the Administrative Office to request your enrollment package.*

If you acquire a spouse or child after you become eligible, coverage will begin for the new Dependent on the date acquired if you are enrolled in the indemnity medical plan. If you are enrolled in a prepaid medical plan, coverage for a new spouse will begin on the first day of the month following your marriage provided the spouse is enrolled within 30 days, or on the date of birth for a new born child provided the child is enrolled within 30 days. *All Dependents must be enrolled within 30 days of the date acquired if you are enrolled in a prepaid plan. Failure to enroll during this period will result in no coverage for the Dependent until the next Open Enrollment period.*

Benefits for Active Employees and Dependents include life insurance, (accidental death and dismemberment benefits for Employees only), medical, prescription drugs, dental and vision benefits.

Continuing Eligibility

After you have satisfied the hours requirement for initial eligibility, you will continue to be eligible for each future month for which contributions have been made on your behalf.

Family Medical Leave Act (FMLA) – Active Employees Only

Under the Family and Medical Leave Act (FMLA), your employer must continue to pay for your health coverage during any approved leave. In general, you may qualify for up to 12 weeks of unpaid FMLA leave each year if:

1. Your employer has at least 50 employees;
2. You worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 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 medical condition,
or
 - c. Your own serious health conditions.

Details concerning FMLA leave are available from your employer.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Active Employees Only

Under this federal act, you may continue coverage for yourself and your Dependents for up to 24 months while you are on military leave. If you make this election, you must submit any self-payment necessary, which may include administrative costs, to the Administrative Office. For military service of 30 days or less you need only pay your normal share of the contribution, if any. For military service of at least 31 days and up to 24 months you must submit the full contribution, in addition to any administrative costs of up to 2%, to the Fund Administrator. If you do not continue your coverage during a military leave, it will be reinstated at the same benefit level you received before your leave (including the availability of your unused hour bank), provided that you meet the eligibility criteria established under USERRA. For more information about this Act, contact the Fund Administrator. USERRA only applies to the Active Employee; it does not apply to Dependents on active duty.

Dependents of Active Employees

Covered Dependents

An Active Employee's covered Dependents include his:

- Legal spouse; or
- Domestic Partner which means a person who has registered as a Domestic Partner with the State of California. Domestic Partners will become eligible on the first day of the month following the month the Plan Administrative Office receives proof of Domestic Partner status in the form of an official certification of registration of domestic partnership with the State of California and an affidavit of "dependency" for tax purposes; and
- Unmarried child or children under age 19 including his natural child, a legally adopted child, a child legally placed with the Active Employee for adoption, and a child for whom the Active Employee has acquired legal guardianship; or
- The unmarried step-child or children who are under the age 19 and who live with the Active Employee in a parent/child relationship and is solely dependent upon the Active Employee for support and maintenance, provided the requirements

have been continuously in effect for 90 days from the date of marriage and the Active Employee has provided a sworn affidavit to this effect; or

- Unmarried child age 19 to age 23 who normally resides with the Active employee, who is financially dependent upon the Active Employee for support and who is a full-time student in a qualified educational institution.

The term “qualified educational institution” means high schools, junior colleges or other two-year colleges granting two-year degrees; universities or colleges granting four-year degrees or post-graduate degrees; or proprietary schools such as business colleges, professional schools, and trade and technical schools which are established as other than evening schools exclusively.

The term “full-time student” means the child is enrolled for 12 units or more per semester or 8 units per quarter or, in a proprietary school is enrolled for a minimum of 25 hours of classroom attendance per week on a five-day week schedule.

Coverage for a full-time student will continue during school vacation provided the child enrolls in the following semester, or in the case of the child’s graduation, coverage will continue for three additional months following the date of graduation.

In the event a child who is a full-time student becomes disabled and is unable to attend school, coverage will only continue until the first day of the school’s next regular session which follows the date established by a Physician’s written statement to the Administrative Office that the student is capable of full-time school attendance.

In no event will coverage for a full-time student continue if sufficient proof of school attendance is not submitted if requested, or the student fails to attend school in accordance with the eligibility rules established above.

- A child who is handicapped, regardless of age, provided the child at the time of attainment of the limiting age of 19 or 23 was disabled and incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains primarily dependent upon the Active Employee for support and maintenance. Proof of the child’s incapacity must be provided to the Administrative Office within 31 days of the date the child attains age 19 or 23 and thereafter as may be required but not more often than once each year after the two-year period following the child’s attainment of age 19 or 23.
- A child who is an “alternate recipient” under a Qualified Medical Child Support Order (QMCSO) will be recognized as a dependent under the Plan pursuant to the order if the child is not already covered by the Plan. A Medical Child Support Order will be recognized by the Plan and your dependent(s) will be covered so

long as the order or notice is qualified and in conformance with the written policies and procedures adopted by the Plan in accordance with the Omnibus Budget Reconciliation Act of 1993 (as amended by the Personal Responsibility and Work Opportunity Act of 1996 and the Child Support Performance and Incentive Act of 1998). A Medical Child Support Order (MCSO) is a court order, judgment or decree under state domestic relations law (or order or notice issued through an administrative process established under state law which has the force and effect of law in that state or a National Medical Support Notice) requiring that health benefit coverage be provided to a child under a parent's Health Plan. A copy of the written Medical Child Support Order procedures is available from the Administrative Office at no charge.

In order for Dependents to be covered, you must supply the Trust with a copy of your marriage license for spousal coverage and copies of birth certificates for coverage for dependent children.

Your spouse must have met all the requirements of a valid marriage contract in the state of residence where they were married (however, a spouse who is legally separated from an employee is eligible for coverage under the Plan).

Dual Coverage

When a husband and wife are both enrolled for coverage as Active Employees under this Plan, each has the option to enroll eligible Dependents for coverage. The combined maximum contractual benefits to which husband and wife are entitled will not exceed the aggregate of 100 % of the Usual and Customary Charge(s) for the Allowable Expense(s). (See Coordination of Benefits section for claims handling procedures)

Effective Date of Coverage for Dependents of Active Employees

Dependents that are eligible and enrolled concurrently with you will have coverage begin on the same date as you. If you acquire a Dependent at a later date, the dependent's coverage will be effective on the date he/she becomes an eligible Dependent.

In the case of a stepchild, coverage will not become effective until 90 days after the date of your marriage to the child's parent.

A Dependent child born (or an adopted child placed in your custody) after the effective date of your coverage, is eligible from the date of birth (placement). **However, if you are enrolled in Aetna or Kaiser, Aetna or Kaiser must be notified of the birth (placement) and the child must be properly enrolled within the first 30 days of birth (placement) or the carrier will deny coverage for the child until the Trust Fund's next open enrollment period.** A dependent under a Medical Child Support Order is eligible from the date of the court order or upon receipt of the order by the Trust Fund, whichever is later.

Termination of Coverage for Active Employees and Dependents

Termination of Coverage for Active Employees

An Active Employee's coverage under the Plan will cease on the earliest of the following:

- The date of termination of the Health Plan;
- The date of termination of participation in the Health Plan by the Active Employee's employer if the Employee continues to work for the Employer;
- The date the former Employer ceases to have an obligation to contribute to the Plan pursuant to a termination of the Collective Bargaining Agreement if the Employee continues to work for the Employer;
- The date of the Active Employee's death;
- The date the Active Employee becomes a full-time member of the armed forces of any country except as otherwise provided in the Plan in accordance with USERRA;
- The date of expiration of the period for which the any required self- payment is not made in a timely or sufficient amount;
- On the first day of the second month following the month in which the Employee has less than 130 hours of Covered Employment required to maintain eligibility status (See Eligibility and Effective Dates section), except when coverage is extended under the terms of any Extension of Coverage provision, Self-payment, COBRA or Disability;
- If a Participating Employer fails to make a contribution on behalf of the Active Employee under the terms of the Collective Bargaining Agreement or Participation Agreement and the Active Employee is still employed by the Participating Employer;
- The date an Active Employee works for a non-signatory employer in the trade, craft or industry covered under the IBEW Local Union 440-NECA Collective Bargaining Agreement; or
- If the Active Employee knowingly works for an employer that ceases to be a Participating Employer who is signatory to a Collective Bargaining Agreement requiring contributions to this Trust fund.

If eligibility ends, coverage may be continued under the terms of COBRA. (see page 20 for details)

Termination of Coverage for Dependents of Active Employees

Coverage for Dependents of Active Employees will cease on the earliest of the following:

- The date of modification or termination of the Health Plan;
- Date of the Active Employee's death, except, the surviving Dependents will be entitled to continue coverage under the Active Employees' Health Plan until the Active Employee's Hour Bank has been exhausted (see bank of hours rules);
- The date the Active Employee enters full-time service with the armed forces of any country. However in such event, the Active Employee may elect to continue coverage for himself and his or her eligible dependents while in the uniformed services of the United States for a period of time as further explained on page 15 under the Uniformed Services Employment and Reemployment Rights Act (USERRA) coverage;
- The date the Active Employee's coverage ceases, unless the loss of coverage is only because the maximum benefit payments under the Plan have been reached (see Medical Schedule of Benefits);
- The date an Active Employee becomes eligible as a Retired Employee, coverage will cease for the Dependent children;
- For the spouse of the Active Employee, the date of the final divorce decree;
- The date of the Dependent's entry into the armed forces of any country;
- The day the Dependent no longer satisfies the Plan definition of Dependent;
- The date of expiration of the period for which the Participant last made the required self-payment for coverage; or, if COBRA was elected, the date of expiration of the applicable COBRA period or the end of payments for COBRA if earlier.
- The date coverage for dependents ceases under the Plan.
- The date any required self-payment is not made.

If eligibility ends for a covered Dependent, coverage may be continued under the terms of COBRA (see page 20 for details).

Continuation Coverage Rights Under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” An Active Employee, and the Active Employee’s spouse and Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Active Employee, you will become a qualified beneficiary *if you lose your coverage* under the Plan because of one of the following qualifying events:

- The Active Employee’s hours of employment are reduced; or
- The Active Employee’s employment ends for any reason other than gross misconduct.

Note: Loss of coverage due to working in non-Covered Employment or being on an approved leave of absence under FMLA is not a qualifying event. However, if you fail to return to work from a leave of absence under FMLA, you will then be given the option of continuing coverage under COBRA.

If you are the spouse of an Active Employee, you will become a qualified beneficiary *if you lose your coverage* under the Plan because of any of the following qualifying events:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- You become divorced from your spouse.

Dependent children of Active Employees will become qualified beneficiaries if they lose coverage under the Plan because of any of the following qualifying events:

- The parent-Active Employee dies; or
- The parent-Active Employee's hours of employment are reduced; or
- The parent-Active Employee's employment ends for any reason other than his or her gross misconduct; or
- The parents become divorced; or
- The child stops being eligible for coverage under the Plan as a "Dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Fund Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Active Employee, or commencement of a proceeding in bankruptcy with respect to the Participating Employer, the Fund Administrator will provide you (or your beneficiary, in the event of the death of the Active Employee), with notification of your rights to COBRA continuation coverage.

Note: The period of COBRA continuation coverage will run concurrently with any period of time coverage was extended through self-payment and will be measured from the date of loss of eligibility.

You Must Give Notice of Some Qualifying Events

For some qualifying events (divorce of the Active Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Fund Administrator within 60 days after the qualifying event occurs. You should also notify the office in the event of the death of the Active Employee.

The Fund Administrator of the Riverside County Electrical Health Plan is Allied Administrators, with which the Board of Trustees has contracted to administer the day-to-day matters of the Fund, including COBRA.

You must send notice of a qualifying event to:

**Board of Trustees
Riverside Electrical Health and Welfare Trust Fund
c/o Allied Administrators
2831 Camino Del Rio South, Suite 311
San Diego, CA 92108
(800) 736-0401**

Information and Documentation Required for Notification of a Qualifying Event

Your notice of a qualifying event must include sufficient information for the Fund Administrator to be able to identify you, along with the type and proof of the qualifying event.

Identification should include the Active Employee's name, your name (if a Dependent), Social Security Number of the Active Employee and the address and telephone number where you can be reached.

Proof of a qualifying event should include any other of the following applicable documentation: a copy of the divorce decree; a copy of the certified death certificate; a copy of a marriage license, a copy of the birth certificate or legal placement of a child for adoption; or, a copy of a Social Security Disability award.

Adding a New Dependent

If you have a Dependent child by reason of birth or placement for adoption during a period when you are receiving COBRA continuation coverage, you also have the right to elect COBRA continuation coverage for that child. For purposes of determining the extension period, the qualifying event for this type of child is the same qualifying event as the employee parent and the child is entitled to the same rights as any other qualified beneficiary. If you wish to add a new spouse, your spouse may be covered for the time remaining under your COBRA period. The spouse is not considered a qualified beneficiary and does not, therefore, have the same rights as other qualified beneficiaries.

How is COBRA Coverage Provided?

Once the Fund Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Active Employees may elect COBRA continuation coverage on

behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Active Employee, your divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Active Employee's hours of employment, and the Active Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Active Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally last for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Upon receipt of your election, if you are not eligible for COBRA, you will receive notification from the Fund Administrator indicating why COBRA is not available.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Fund Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. (Refer to page 22 for the required documentation)

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum total of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any Dependent children receiving continuation coverage if the Active Employee or former Active Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or if the Dependent child stops being eligible under the Plan as a Dependent child but only if the

event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

COBRA Extension Period under USERRA

If you would lose coverage due to active duty with the armed forces of the United States, you may continue coverage for yourself and your enrolled dependents for up to 24 months. (Refer to page 15 for more information on USERRA)

What Benefits Can Be Continued under COBRA?

When you experience a qualifying event, you will be given the option of continuing most of the benefits you had on the day before your loss of coverage. Under COBRA, you cannot continue life insurance benefits. You will have the option of continuing only your medical and prescription drug benefits or your medical, prescription drug, dental and vision benefits. If benefits for Active Employees and their Dependents change, the benefits you have will also change.

What is the Cost of COBRA Continuation Coverage?

The cost for COBRA continuation coverage depends upon the coverage you elect to continue and the type of qualifying event:

- You will be required to pay 102% of the full cost for those benefits for a qualifying event that provides 18, 24 or 36 months of COBRA coverage.
- During the disability extension period (additional 11 months of COBRA continuation coverage) you will be charged 150% of the cost of coverage continued.

Premiums for COBRA coverage may be changed for all COBRA Participants once each year unless there is a change in coverage that allows a change in COBRA premiums under federal law or you add or delete family members which results in a change in premium.

How Do I Make COBRA Premium Payments and When Are They Due?

When you experience a qualifying event, you will receive a separate notice of your rights to continue coverage under COBRA. The notice will advise you of your options and the cost of the benefits.

You will have 60 days (the election period) during which you must inform the Fund Administrator that you want continuation coverage.

Your first payment must be received within 45 days from the date you have made your timely election for COBRA continuation coverage.

The first payment must include the cost for benefits from the date of loss of coverage to the first day of the month of your first payment.

Subsequent COBRA payments are due on the first day of the month and will be considered delinquent if not received within 30 days. If your payment is delinquent, COBRA coverage will cease and it cannot be reinstated.

What Happens If I Need to Have Services Before I Have Made My Election and Payment for COBRA Coverage?

Technically, you do not have coverage until you have paid the premium for that month of coverage. If a provider calls to verify your coverage during this period, they will be told that services will only be covered if the COBRA premium is received in a timely manner. You may be required to pay for services in advance. In the event you do receive services for which a Plan payment was made, you will be responsible for reimbursement to the Plan if it has paid any claims in error.

Termination of COBRA Continuation Coverage

You may lose your continuation coverage before the end of your maximum coverage period for any of the following reasons:

1. If the required premium is not paid in a timely manner, coverage will cease;
2. If you become covered under another group health plan, after the date of COBRA election, that does not contain any applicable exclusion or limitation with respect to any preexisting condition;
3. If all group health plans are terminated;
4. If you become entitled to Medicare coverage after the date you elected COBRA continuation coverage (if you are age 65 or over and receive or have applied for Social Security or qualify for Social Security at an earlier age due to a disabling condition) you are considered to be entitled to Medicare;
5. You request cancellation of COBRA coverage in writing;

6. If the group health plan terminates the coverage for cause for similarly situated Active Employees (such as fraud), then the qualified beneficiary's coverage can be terminated on the same basis;
7. The date your former employer no longer contributes to the Plan, if the employer continues to provide health coverage for any of its employees.
8. If you are no longer determined to be disabled by the Social Security Administration if you are receiving the 11 month disability extension.

Plan or Benefit Changes

As a qualified beneficiary, you are entitled to the same open enrollment rights as Active Employees. Although you may only continue benefits you had on the day before a qualifying event, you change plans during the Open Enrollment period.

Plan benefits may be modified or amended during the period of your COBRA continuation coverage which may result in a change in premiums. Your COBRA premiums will be based upon the benefits you have.

You are also entitled to HIPAA special enrollment rights such as adding coverage for newly acquired family members or when an eligible individual declines coverage due to alternative coverage and later loses such coverage due to certain qualifying reasons.

Conversion Option

When your coverage ends, you have the option of converting your group coverage to an individual plan if conversion is available. You have 60 days to convert your coverage. You should contact your insurance carrier for information on conversion plans and their costs prior to the date of your loss of coverage. Conversion plans do not provide the same level of coverage as the plan for Active Employees and Dependents, and they generally cost more. There are no conversion programs for the Indemnity Medical, Dental, Drug and Vision programs

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Fund Administrator informed of any changes to your and family member's address. You should also keep a copy, for your records, of any notices you send to the Fund Administrator. The address of the Fund Administrator is located in the front of this booklet.

California COBRA option

If you have a qualifying event that results in less than 36 months of coverage, and you have maintained that coverage for the maximum period of time, you may be eligible to continue your medical benefits for an additional period of time under California COBRA. This coverage is only available to Participants enrolled in the Kaiser or Aetna prepaid medical plans. You can receive additional information from the carriers. Premiums for this coverage approximate 110% of the cost. California COBRA is not administered by this Trust Fund; you will pay your premiums to the carrier.

SPECIAL TAX CREDIT FOR TAA INDIVIDUALS

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for Trade Adjustment Assistance (TAA). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for COBRA coverage. If you have questions regarding these two new tax provisions, or if you want to know if you are eligible for this program, you may call the Health Care Tax Credit Customer Contact Center toll free at **(866) 628-4282**. TTD/TTY callers may call toll free at **(866) 626-4282**. More information about the Act is also available at www.doleta.gov/tradeact/2002_index.asp.

This tax credit is also available if you are receiving benefits from the Pension Benefit Guaranty Corporation (PBGC) and are at least 55.

COMPLIANCE WITH LAW

The Board of Trustees has adopted procedures for complying with COBRA based on their interpretation of the law. The Board reserves the right to make any changes they deem appropriate or as required by law.

CERTIFICATION OF CREDITABLE COVERAGE UNDER HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this Trust Fund supply written certification of creditable coverage when your coverage ceases (either under active coverage or COBRA coverage) or when requested by you within two years after coverage ceases. The certification will specify the period of creditable coverage under the Trust Fund (including COBRA, if applicable). There are no special open enrollment requirements under HIPAA because neither Participants nor their dependents may decline coverage under this Plan. Dependents may be added within thirty (30) days of acquiring a new dependent subject to proof of birth, marriage, etc. There is no additional premium charged for dependent coverage.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1999

In compliance with the Women's Health and Cancer Rights Act of 1999, effective January 1, 2000, a participant or beneficiary receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, will be provided coverage for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications, including lymphedemas, in a manner determined in consultation with the attending Physician and patient.

Newborns' and Mothers' Health Protection Act

This federal law applies to the Trust. It generally forbids health plans and health insurance issuers from limiting a Hospital stay benefit to any less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section for both the mother or newborn child in connection with childbirth. Plans and insurers may not require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay that does not exceed those described. However, the attending provider may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable), after consulting with the mother, without violating this law.

Indemnity Plan Medical Benefits

The Riverside County Electrical Health Plan offers its active members different medical benefit plans to choose from. The following section describes the benefits that are available to you if you enroll in the self-funded fee-for-service Indemnity Medical plan. If you are electing coverage under one of the HMO medical plans, request a booklet describing those benefits from the Administrative Office.

Choice of Providers

You have a choice of obtaining health care services and supplies from providers participating in the Preferred Provider Organization (PPO providers) or any other provider of your choice (Non-PPO providers). The participating Preferred Provider Organization for the self-funded Indemnity Plan is the Beech Street PPO Network.

PPO Providers

Generally, when you elect to use a PPO provider for covered services and supplies, the Plan will provide a better benefit. The benefit enhancements are described in other sections of this schedule. The difference in payment between a PPO provider and a Non-PPO provider ***may be significant***. Please read the schedules carefully.

NOTE: Certain covered services and supplies may not be available directly through a PPO Hospital or Physician. In certain instances Hospitals and Physicians may try to refer you to specialty services through non-PPO Providers. You should refer to the provider directory distributed by Beech Street to determine if any particular specialty is included in the network. If it is, tell the Hospital or Physician to refer you within your network.

Non-PPO Providers

Non-PPO providers are those providers who are not participating in the Beech Street Preferred Provider Organization. Benefit levels for such providers can be significantly less than PPO benefit levels to encourage you to use PPO providers whenever possible.

Important Note on Ancillary Services: The Trust will pay 100% of URC allowance for ancillary services provided by a Non-Contract Provider while a participant is receiving services in a PPO contracted hospital or PPO out-patient surgical facility, while under the care of a PPO physician. Ancillary services include x-ray, laboratory, anesthesia providers and emergency room physicians for which the patient does not have a choice of provider.

Required Utilization Management Program (U.R.)

Benefits provided by the Indemnity Medical Plan are subject to compliance with the requirements of the Utilization Management Program as described below and in any packet of information distributed by the Utilization Management Organization. These requirements are designed to encourage you and your Dependents to obtain quality medical care while utilizing the most cost efficient sources.

Hospital Review

Compliance Procedures – Important Note:

Prior to a scheduled or elective Hospital admission or within 72 hours following an emergency Hospital admission, the patient or family member must phone the Utilization Management Organization for authorization. The Utilization Management Organization, which is assisting in Hospital cost management for the Plan is:

Alicare Medical Management, Inc. - Case Management and Utilization Review

Your ID card includes a phone number for the Utilization Review Organization and additional information to assist you in complying with these requirements. Alicare Medical Management, Inc.'s Utilization Management/UR phone number is 1-800-433-6915. Alicare Medical Management, Inc. may be reached between the hours of 7:30 a.m. to 5:30 p.m.

Penalty for Non-Compliance

If the authorization requirements are not completed for a Hospital admission, your benefits will be reduced to 50% of Covered Medical Expenses. This benefit reduction will apply to all services rendered, including Physician's charges for the Covered Person during the period of Hospital Confinement.

Any additional expenses, which become your responsibility for failure to comply with these requirements will not be considered Covered Medical Expenses and, thus, will not apply to any Deductible, any benefits the Plan may pay, or the out-of-pocket maximums of the Plan.

Alicare Medical Management's authorization is not a guarantee of coverage. The Utilization Review Program is designed ONLY to determine whether or not a proposed course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Indemnity Medical Plan's Covered Medical Expenses as well as its limitations and exclusions.

Special Notices

It is the Participant's or Covered Person's responsibility to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, *you or your eligible Dependents should contact the review organization to make certain that the Hospital or attending Physician has received the appropriate authorization.*

The Benefit Plan

Calendar Year Deductible

The Deductible is an amount which you and your Dependents must pay for Allowable Medical Expenses each Calendar Year. A different deductible applies if you do not use contracting PPO providers. The deductibles are:

Maximum Calendar Year Deductible	Using PPO Providers	Using Non-PPO Providers
Per Person	\$200	\$250
Per Family	\$400	\$500

The Deductible applies to each covered member of your family; however, if the total out-of-pocket expense for Covered Expenses for your family totals the Maximum Calendar Year Deductible, no other Deductible will be required for any family member during the balance of the year. Once your Deductible has been satisfied, Plan payments will begin.

Deductible Carry-over

Allowable Medical Expenses incurred in the last three months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward satisfaction of your Deductible for the next Calendar Year.

Common Accident Provision

If two or more family members are injured in the same accident, only one Deductible will be taken from the total of all Allowable Medical Expenses incurred as the result of the accident during the Calendar Year in which the accident occurred.

Plan Payments

Preferred Provider Organization

The Board of Trustees has selected the Beech Street PPO Network as the Preferred Provider Organization (PPO). PPOs help you obtain quality care at an affordable price. Contracts have been negotiated with Hospitals, Physicians and allied health professionals (such as laboratories, radiologists, and physical therapists) who have agreed to provide medical services at pre-arranged rates. We call these preferred providers.

Using a PPO provider does not require special enrollment. All you have to do is choose to receive medical care from one of the Physicians, Hospitals, or other health care providers that contract with the Beech Street PPO Network. To locate a PPO provider, you can log onto www.beechstreet.com or call **(800) 227-7464**. The Administrative Office can also assist you.

Failure to use a PPO provider under the Indemnity Medical Plan will result in significantly Higher Expenses to you.

Questions regarding these items should be directed to the Administrative Office. The Administrative Office can be contacted at **(800) 736-0401**.

What the Plan Pays

Your Medical Plan covers a wide range of services, including those discussed here. If you have a medical care expense that is not specifically listed here, call the Administrative Office where the personnel will be pleased to help you determine whether or not the expense is covered.

If you use a provider from the PPO network, the Plan will pay a percentage of the "Covered Expenses." Covered Expenses are defined under the PPO network as the contract rate(s) the various providers have agreed to charge for their services. If you use a non-PPO provider, "Covered Expenses" are defined as what is Usual and Customary. The Plan will pay a percentage of the "Usual and Customary Charges". The Schedule of Benefits shows the percentages payable under the Plan.

Covered expenses are further defined for both PPO and non-PPO providers as charges for services and supplies that are:

- Medically Necessary for treatment or diagnosis of the Injury or Illness; and
- Ordered or prescribed by a Physician.

The Plan will not pay for any treatment that is not Medically Necessary in the opinion of the Trustees or is not prescribed by a Physician (except as specifically provided).

What You Pay

You pay the difference between the charge or PPO contract rate and the amount the Plan pays which includes any applicable Deductible. This also includes the difference between what is allowed under the Plan and the total amount of medical expenses incurred. If you use non-PPO providers, you pay the difference between what the Plan pays and the amount charged by the provider.

Where Covered Medical Expenses (including prescription drug expenses) are paid at less than 100%, the percentage payable will apply until the out-of-pocket cost for such expenses incurred by a Covered Person in a Calendar Year totals \$2,500 if services are provided by a PPO provider. Your out-of-pocket maximum when using non-PPO providers is limited to \$10,000 (including prescription drug expenses) per Covered Person based on Usual and Customary Charges. However, in no event will the Plan's payments exceed the Lifetime Maximum for a Covered Person. This out-of-pocket maximum applies once each year to each Covered Person.

Once you have satisfied the Calendar Year out-of-pocket maximum, the Plan will pay 100% of the Allowable Medical Expenses incurred by that Covered Person during the balance of the Calendar Year. However, the payments for some services or benefits will never increase to 100% – those services and supplies that have annual or visit maximums, or maximum dollar amounts such as services for Mental Health and Substance Abuse.

Participants will be reimbursed for any prescription co-payments charged subsequent to meeting their PPO or Non-PPO annual out-of-pocket maximum, for the remainder of the calendar year. To obtain reimbursement, of the co-payment, the receipt from the pharmacy, which includes the medication name, dosage, strength, and co-payment charged, must be submitted to the Trust office. Please be sure the participants name and social security are shown.

All benefit payments will continue to be subject to compliance with the Utilization Management – Utilization Review (U.R.) program. Should you not comply with the U.R. program the percentage(s) payable will be reduced. Likewise, if you don't use a PPO provider, you will have more out-of-pocket expense.

Plan Maximums

The maximum payable for all covered expenses for each Covered Person will not exceed, in the aggregate, the Maximum Plan Benefit shown below which applies to all periods a person is eligible for coverage in the Fund. Any lesser Maximum Benefits and Maximum Allowances are also applicable to all periods a participant is covered under the Fund. Other maximums may apply to specific periods, conditions or types or levels of care and are as specified.

Medical Indemnity Plan Lifetime Maximum

All participants and their eligible dependents on the Medical Indemnity Plan are subject to a payment limitation of \$1,000,000 of covered charges over their lifetime. Once the \$1,000,000 lifetime maximum is exhausted, medical and prescription drugs will be terminated for the participant or dependent as of the date the threshold is met. Lifetime maximums are cumulative. Members who lose eligibility due to a lack of qualifying employment hours and do not self-pay for continuation of coverage, will not restart a lifetime maximum upon re-entry into the Indemnity Medical Plan.

Covered Medical Expenses

Except as otherwise noted below or in the **Schedule of Benefits**, Covered Medical Expenses are paid at the contract rate if a PPO provider is used or on the basis of Usual and Customary Charges if a non-PPO Provider is used (non-PPO providers may be used under the Indemnity Medical Plan only). Covered Medical Expenses are subject to the **Definitions, Limitations and Exclusions** and all other provisions of this Plan Booklet and other provider agreements. In general, services and supplies must be approved by a Physician and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

For benefit purposes medical expenses are considered to be incurred on the latest of the following dates:

- The date of purchase;
- The date delivery is made; or
- The actual date a service is rendered.

The following services and supplies are considered Covered Medical Expenses:

Accidental Injury – Services and supplies for a bodily injury that is caused by external forces under unexpected circumstances and which does not arise out of or in the course of the employment of a Covered Person. Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

Acupuncture / Acupressure when Medically Necessary.

Alcoholism – see "Substance Abuse"

Ambulance – Medically Necessary transportation by a Professional licensed ambulance service when used to transport the Covered Person to and from a local Hospital or Skilled Nursing Facility.

Ambulatory Surgical Center – Services and supplies for treatment at an Ambulatory Surgical Center which includes any public or private establishment that:

- Complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- Has an organized medical staff of Physicians;
- Has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- Provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
- Does not provide services or other accommodations for patients to stay overnight.

An Ambulatory Surgical Center will not be covered if (1) its primary purpose is the performance of abortions or (2) it is maintained as an office by a Physician or Dentist for the practice of medicine or dentistry.

Birthing Centers – Treatment received at a Birthing Center which includes a special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility which:

- Is in compliance with licensing and other legal requirements in the jurisdiction where it is located;
- Is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients:
- Has organized facilities for birth services on its premises:
- Provides birth services, which are performed by or under the direction of a Physician specializing in obstetrics and gynecology:
- Has 24-hour-a-day registered nursing services; and
- Maintains daily clinical records.

Blood – Services and supplies necessary for the administration of blood, blood products or blood plasma, but not the cost of any such blood, blood product or blood plasma.

Chemical Dependency – see "Substance Abuse"

Chemotherapy that is Medically Necessary and ordered by a Physician.

Chiropractic Care – Manipulation to anatomically correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain. Coverage for chiropractic care includes related x-rays and is limited to the lesser of a maximum allowance of 26 visits per Calendar Year, up to \$1,500 per Calendar Year maximum and or a \$10,000 Lifetime Maximum while otherwise eligible. Chiropractic care may be administered by a Physician who holds the designation of Doctor of Osteopathy (D.O.) or a Doctor of Chiropractic medicine (D.C.).

Diabetic Instruction Program – Charges of a diabetic Outpatient center and for the services of a Physician or other certified professionals who are knowledgeable about the treatment of diabetes (such as registered nurse, registered pharmacist or registered

dietitian) for the purpose of enabling diabetics and their families to understand and practice daily management of diabetes. Coverage is limited, however, to a maximum benefit of \$100 which applies to the entire period(s) a participant is covered under the Plan.

Diagnostic Services – Diagnostic laboratory and x-ray expense, including charges for electrocardiograms, basal metabolism testing, or similar diagnostic testing as Medically Necessary.

Durable Medical Equipment – Rental of durable medical equipment (but not to exceed the purchase price) or purchase of such equipment where only purchase is permitted – that is prescribed by a Physician and required for temporary (generally for a period not to exceed six months) therapeutic use in treatment of a short term Sickness or Accidental Injury.

Durable medical equipment includes such items as braces, crutches, wheelchairs, Hospital beds, dialysis equipment, etc., which (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home. Modifications to a home or automobile to accommodate the installation of Durable Medical Equipment or to facilitate entrance or exit ***are not Covered Medical Expenses***.

Family Planning Services – Family planning services, limited to one (1) visit per year to obtain contraceptive, whether device or medication (oral contraceptives, Norplant, IUD, diaphragm, Depo-Provera and birth control injectable hormones) and including charges for a Pap smear prior to obtaining such contraceptives. Family Planning Services are limited only to the member and/or dependent spouse and may only be provided through a PPO Physician.

Eligible family planning services will also include surgical procedures for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female). Also, reversals are not covered (see "Sterilization Reversal Surgery" under the Medical Limitations and Exclusion section).

Health Assessment – An annual health assessment for a Covered Person under the age of 18 when performed by a contracting PPO provider after a \$15 copayment. Allowable Expenses include charges for vision screening, hearing testing, immunizations, and laboratory testing. An annual health assessment for a Covered Person 18 years of age or older when performed by a PPO provider after a \$15 copayment up to a maximum payment of \$50.

Hemodialysis when Medically Necessary

Home Health Care – Services and supplies as listed herein which are furnished by a Home Health Care Agency to a Covered Person who is under the care of a Physician and

which are furnished in accordance with a home health care plan which is established and periodically reviewed by the attending Physician. The attending Physician must certify that the proper treatment of the Sickness or Accidental Injury would require confinement as a resident Inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the home health care plan.

Covered Home Health Care Agency expenses will include visits by any of the following professionals:

- A registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.) on a part-time or intermittent basis; or
- Home health aids under the supervision of an R.N. on a part-time or intermittent basis; or
- Physical, occupational or speech therapist.

Home health care services will be covered for the 90-day period following confinement in a Hospital or Skilled Nursing Facility for at least five (5) days.

Covered Home Health Care Agency expenses will also include medical supplies, drugs and medicines prescribed by a Physician, laboratory services, and special meals prescribed by a Physician, nutritionist or dietitian, but only to the extent that such charges would have been covered if the patient had remained in the Hospital or Skilled Nursing Facility.

Hospice – A facility or designated part of a Hospital that meets the requirements for participation as a Hospice Facility under Medicare.

Hospital Services – Inpatient care in a Hospital including:

Hospital Daily Room and Board Charges limited to (1) the contracted rate for a PPO Hospital or (2) the Semi-Private Room Rate or two times the Semi-Private Room Rate for an Intensive Care Unit plus ancillary services and supplies in a Non-PPO Hospital. Benefit payments will be reduced without prior authorization for an overnight hospital stay that is not an emergency. See page 29 for details.

Hospital ancillary services and supplies provided on an Outpatient basis.

Mammography – Mammography at frequencies and ages shown below, for breast cancer screening:

- A baseline mammogram for women ages 30 to 39, inclusive;
- A mammogram for women ages 40 to 49, inclusive; every two years or more frequently based on the patient's Physician's recommendation; and
- A mammogram every year for women age 50 and over.

Medical Supplies – Medical supplies such as casts, splints, trusses, cervical collars, surgical dressings, colostomy bags and related supplies, catheters and cardiac pacemakers.

Mental Health Care – For Plan purposes, a mental health condition will include serious emotional disturbances of a child, schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa EXCEPT for those conditions which are expressly excluded in the list of **Medical Limitations and Exclusions** (i.e. childhood learning and behavior disorders, hypnotherapy, marriage and family counseling, sex counseling, sex therapy and vocational testing and training).

Inpatient treatment for Mental Health Care (whether using a contracting or non-contracting provider) has a combined limit of 15 days per calendar year. Outpatient treatment (whether using a contracting or non-contracting provider) has a combined limit of 20 visits per calendar year. Prior authorization is required and must be obtained by calling **(800) 433-6915**.

Midwife – Services of registered nurse-midwife, certified to practice as a midwife by the American College of Nurse-Midwives and authorized to practice as a nurse-midwife under state regulations.

Nursing Services – Services of a registered graduate nurse (RN) for private duty nursing services when Medically Necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type.

Orthotics – Custom molded shoe inserts obtained from a provider licensed to dispense such devices will be limited to once every two years. The Deductible will be waived and benefits will be paid at 80% to a maximum of \$250.

Oxygen – Oxygen and services and/or supplies for the administration of oxygen.

Pap Smear – see "Family Planning Services"

Physical Therapy / Respiration Therapy – Professional services of a licensed physical or respiratory therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.

Physician Services – Medical and surgical treatment by a Physician or anesthetist (M.D. or D.O.), including office or home visits, clinic care and consultations. See "Second Surgical Opinion" below for requirements applicable to second surgical opinions.

Pregnancy – Pregnancy expenses are covered to the same extent as any other Sickness. Coverage will not include expenses incurred by a surrogate mother who is not an Eligible

Participant, or for expenses incurred by a dependent other than a spouse of the employee.

Prosthetics – Initial artificial limbs, eyes or other prosthetic appliances required to replace natural limbs, eyes or other body parts lost/removed. Implants and external breast prostheses following a surgical mastectomy subject to the Women’s Health and Cancer Rights Act of 1999.

Radiation Therapy – Radium and radioactive isotope therapy.

Rehabilitation Center – see Skilled Nursing Facility.

Second Surgical Opinion – A second surgical opinion consultation rendered within one (1) month of the first surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of proposed surgery must be qualified to render such a service, either through experience, specialist training or education, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation if the second opinion obtained does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

Skilled Nursing Facility or Rehabilitation Center – Room and board and ancillary supplies which are provided by a Skilled Nursing Facility, limited to a daily allowance equal to 50% of the Semi-Private Room Charge of the transferring Hospital, but only when confinement:

- Is preceded by confinement of at least 3 days in a Hospital; and
- Is for the same condition causing the preceding confinement; and
- Commences within 15 days of discharge from such prior confinement.

A maximum of 60 days of Skilled Nursing Facility confinement is allowable for all confinements due to the same or related causes.

Speech Therapy – Services by a qualified speech therapist to restore or rehabilitate any speech loss or impairment caused by Accidental Injury or Sickness except a mental, emotional or nervous disorder. In the case of a congenital defect that can be corrected or improved with surgery, expenses will be considered only if incurred after surgery for the defect.

Sterilization Procedures – see "Family Planning Services"

Substance Abuse – Benefits for are payable at 50% of contracted rates when using a PPO provider and 50% of Usual and Customary Charges when using a non-contracting

provider. Inpatient benefits are limited to one course of treatment in 12 consecutive months and 5 days per year. Outpatient benefits are limited to 25 visits per calendar year.

Transplants – Organ transplants, which are recognized for reimbursement by Medicare, such as kidney and cornea.

Urgent Care Facilities – Charges incurred on an Outpatient basis at an urgent care or ambulatory medical facility.

Well Child Care – Well child care, up to age 2 (including routine physical exams and related diagnostic services).

Newborns and Mothers Health Protection Act – Under the Newborns and Mothers Health Protection Act, the Plan will provide for a Hospital stay of no less than 48 hours for the eligible mother and newborn child following a vaginal delivery, (with or without complications), and no less than 96 hours for a cesarean birth, unless an attending Physician, in consultation with the mother, approves an earlier discharge. The time periods outlined above begin at the birth of the child. Alicare Medical Management's pre-admission authorization procedures must still be followed; however, Federal law does not permit a preauthorization requirement for Hospital stays of less than 48 hours or 96 hours respectively.

Medical Limitations and Exclusions

Except as specifically stated otherwise, no benefits shall be payable for:

Abortion – An elective abortion procedure or any expenses related thereto, unless the mother's life would be endangered if the Pregnancy were allowed to continue to term. Complications arising out of any abortion, however, are covered as any other Sickness.

Air Purification Units, etc. – Air conditioners, air purification units, humidifiers and electric heating units.

Allergy Testing – Individualized testing and treatment for allergies exceeding the guidelines established by the American Board of Allergy and Immunology.

Biofeedback – Biofeedback, recreational, or educational therapy, or other forms of self-care or self- help training or any related diagnostic testing.

Blood – The cost of whole blood, blood products or blood plasma, whether replaced or not, is not a covered benefit. However, the cost of processing and administration of whole blood, blood products and blood plasma is a covered expense.

Childhood Disorders – Treatment of learning disorders, behavioral problems, mental retardation, hyperkinetic syndrome, or autism of childhood, unless covered otherwise as provided.

Cosmetic Surgery – Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic, except when necessitated by a non-occupational Accidental Injury.

Custodial Care – Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training.

Dental Care – Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, except for treatment of malignancies of the mouth, or as the result of a non-occupational Accidental Injury to sound natural teeth.

Diagnostic Hospital Admissions – Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

Education or Vocational Testing or Training

Exercise Equipment/Health Clubs – Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in Health, Athletic or similar clubs.

Foot Care (routine) – Non-surgical treatment of the feet, treatment of corns, calluses, toenails, or other routine foot care unless the charges are for the removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease.

Genetic Counseling or Testing – Genetic counseling or testing, amniocentesis is not covered unless there are indications of fetal distress and the mother is over 35 years of age. The age requirement for amniocentesis is waived if the procedure is Medically Necessary.

Hair Transplants

Health Assessments performed by non-PPO providers.

Hearing Aids or Related Examinations

Holistic or Homeopathic Medicine – Services, supplies, or accommodations provided in connection with holistic or homeopathic treatment, including drugs.

Hypnotherapy

Impregnation – Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

Marriage and Family Counseling – Counseling for the purpose of resolving family or marital difficulties.

Modifications – Modifications to home or automobile to accommodate the installation of Durable Medical Equipment or to facilitate entrance or exit.

Nicotine Addiction – Nicotine withdrawal programs, facilities or supplies.

Non-Prescription Drugs – Drugs which can be purchased over-the counter and without a Physician's written prescription.

Not Medically Necessary / Not Physician Prescribed – Any services or supplies which are (1) not Medically Necessary, and/or (2) not incurred on the advice of a Physician – except as expressly included herein.

Obesity – see "Weight Control"

Occupational Therapy, Etc. – Occupational therapy (except during an Inpatient Hospital confinement or as included in Home Health Care services), vocational, educational, recreational, art, dance or music therapy.

Orthographic Procedures – Jaw (mandibular) augmentation or reduction procedures.

Orthopedic Shoes – (except when permanently attached to braces and other supportive appliances for the feet.)

Out-of-Area Coverage – Members accessing care outside Beech Street Provider Network service area, will only have use of the non-network benefit on the Indemnity Medical plan.

Personal Comfort or Convenience Items – Service or supplies provided for personal comfort and not necessary for treatment of covered Sickness, Accidental Injury, or Pregnancy including, but not limited to, the purchase or rental of telephone, televisions, orthopedic mattresses, allergy free pillows, blankets and/or mattress covers, wigs, non-prescription drugs and medicines, non-Hospital adjustable beds, waterbeds, motorized transportation equipment, elevators, escalators, professional medical equipment (such as blood pressure kits) or supplies or attachments to such equipment.

Prescription Drugs (Outpatient) – Outpatient prescription drug coverage is provided only under the terms of the Express Scripts prescription drug program. Fertility drugs are not covered under either the Medical Plan or the Express Scripts prescription drug plan.

Preventative or Routine Care – Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, except as may be specifically provided.

Prosthetic Replacements and Prosthetic Repairs – Replacement, repair or maintenance of prosthetic devices.

Self-Procured Services – Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any period of Hospital confinement, which were/are not recommended, approved and certified as Medically Necessary by a Physician, except as may be specifically included.

Sex Change Procedures, Services or Supplies – Sex change counseling, treatment, services or supplies incident to sex change surgery or any resulting complications.

Sex Counseling – Therapy or counseling for sexual dysfunction or inadequacies.

Sterilization Reversal Surgery – Reconstruction (reversal) of prior elective sterilization procedures.

Temporomandibular Joint Dysfunction (TMJ) – Procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome, including the correction of abnormal positioning and relationship of teeth.

Vision Care – Eye examinations for the purpose of prescribing corrective lenses, eye glasses or contact lenses or the fitting thereof, Orthoptics, vision therapy, or other special vision procedures. This exclusion shall not apply to the initial purchase of glasses or contact lenses following cataract surgery covered under this Plan. Vision procedures whose purpose is the correction of refractive error, such as radial keratotomy, lasik surgery, etc. are not covered expenses.

Vitamins or Dietary Supplements

Vocational Testing or Training – Vocational testing, evaluation, counseling or training.

Weight Control – Services or supplies for obesity, weight reduction or dietary control, except when provided for treatment of morbid obesity. Morbid obesity is defined as a Body Mass Index (BMI) of 40 percent or greater through the age of 54 years.

Wigs or Wig Maintenance

Workers' Compensation – The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

- (See also **General Health Care Coverage Exclusions** pages 65 – 68)

PRESCRIPTION DRUG BENEFITS FOR INDEMNITY PLAN ENROLLEES

The Express Scripts prescription drug benefit Plan provides benefits to those Active Employees who have elected medical coverage under the Indemnity Medical Plan. **If you have any questions concerning your coverage election, please contact the Administrative Office at (800) 736-0401 before incurring any prescription expenses.**

Calendar Year Out-of-Pocket Maximum

The medical plan calendar year out-of-pocket maximum of \$2,500 also includes prescription drugs. Participants will be reimbursed for any prescription copayments charged subsequent to meeting the PPO or Non-PPO annual out-of-pocket maximum for the remainder of the calendar year. To obtain reimbursement of the copayment, the receipt from the pharmacy, which includes the medication name, dosage, strength and copayment charged, must be submitted to the Trust office. The participant's name and social security number must also be shown.

Outpatient Prescription Drug Program

Coverage for Outpatient prescription drug purchases is through Express Scripts (EXPRESS SCRIPTS). When filling a prescription at a retail drug store, you are required to use a participating pharmacy that contracts with Express Scripts and you must make a Copayment toward each prescription purchase:

Copayments at retail stores (30-day supply)

Generic Drugs (through formulary)	\$10
Brand-Name Drugs, only available if generic formulary drug is not available	\$20
Non-Formulary Drugs	\$30

90-day supply is required to be purchased through the mail-order program. If they are not, benefits will be payable only for a 30-day supply. However, if the patient has reached his out-of-pocket maximum of the year (see page 33), he may submit his prescription receipt to the administrative office for reimbursement. The receipt must show the specific information relating to the medication and the copayment amount.

Mail Order Prescription Drug Program

The mail-order prescription service is provided through Express Scripts as follows:

Mail Order must be used for any prescription drugs exceeding a 30-day supply. Prescription drugs prescribed for more than 30 days, including diabetic supplies, are available through mail order program for the following copayments:

Copayments through Mail Order (90-day supply)

Generic Drugs (through formulary)	\$20
Brand-Name Drugs, only available if generic formulary drug is not available	\$40
Non-Formulary Drugs	\$60

Note: All maintenance drugs and diabetic supplies may be purchased through the mail order program

Prescription Drug Plan Maximums

Plan Members may get more than a 30-day supply of a prescription drug at a retail store; however, the copayments are lower when using the mail order service. Drugs exceeding a 30-day supply (including diabetic supplies) may be purchased through the mail order program which will dispense up to a 90-day supply of the prescribed drug.

There are no Calendar Year maximums under the present prescription drug plan. However lifetime maximums under the Express Scripts prescription drug program are part of the \$1,000,000 lifetime limitation in the Indemnity Medical plan for Active Employees and their dependents.

Existing Drug Coverages, Formularies and Limits

Members must obtain their prescriptions from an Express Scripts approved pharmacy in order to obtain prescriptions for Plan allowable copayments.

The Express Scripts prescription benefit Plan uses a drug formulary to determine eligible prescriptions. The Plan Formulary is based upon the Express Scripts National Preferred Formulary. Formularies are designed to cover most but not all drugs in each therapeutic class. Formulary limitation will ensure that members are getting the best of what is available without paying excessive prices. You may contact Express Scripts Customer Service at **(888) 201-5853** 24 hours a day for formulary information. You may also obtain the Plan Formulary by going online at www.express-scripts.com. You may register with Express Scripts online to refill prescriptions and to get a complete benefit summary of you prescription drug benefits.

Non-formulary drugs may be purchased, but at a substantially higher copayment than Generic or Brand Formulary drugs covered under this Plan.

Coverage for Medical Tests, Devices and Procedures

There is no coverage under the Express Scripts prescription benefit Plan for medical tests or procedures. Benefits for preventive care services are not provided for under the Express Scripts prescription drug plan.

Certain devices related to the treatment of asthma or diabetes are covered when prescribed by your Physician and obtained at an Express Scripts approved pharmacy. Have your Physician or pharmacist call the Pharmacist Help Desk at **(800) 235-4357** with any questions related to these supplies. ***This telephone number is for Physicians or pharmacists ONLY.***

You may access the Express Scripts provider pharmacy directory online at www.express-scripts.com or you may call customer service toll free at **(800) 206-4005** for assistance in finding the Express Scripts member pharmacy closest to your home.

No benefits are payable for any services received at a non-member pharmacy. Out-of-pocket costs from a non-member pharmacy cannot be credited toward your Plan Deductibles, coinsurance and out-of-pocket maximums

Plan Conditions and Limits for Accessing Emergency Care

If you have an emergency medical situation, please call 911 or call your Physician's office for instructions. The Express Scripts pharmacy benefits Plan is not for emergency use. However, there may be membership or prescription emergencies. Emergency eligibility can be assessed and resolved by calling the Administrative Office or the eligibility hotline at Express Scripts. The eligibility hotline is for members who cannot verify eligibility at the pharmacy and are in urgent need of a prescription due to illness or other issues. The eligibility hotline number is **(800) 767-8866**. Please call the Administrative Office at **(800) 736-0401** first before using the Express Scripts hotline. Most eligibility issues can be handled in a timely manner by the Administrative Office.

Plan Provisions that Require Pre-Authorization or Utilization Review to Access Care

Several drugs or drug classes may require pre-authorization due to cost, class or manner or use in your course of treatment as prescribed by your Physician. The following items will require pre-authorization before you can obtain them at a member pharmacy;

- Retail/Mail Order Prescriptions in excess of \$1,499.99 in total cost
- Retail/Mail Order Compound Drugs in Excess of \$149.99 in total cost

- The Following Drugs Under any Circumstances require pre-authorization- Tazorac, Regranex, Growth Hormones, Aranesp, Epogen/Procrit, Botox, Prolastin, Trentinon (PA required over age 25), Rapitva, Forteo, Amevive, Remicade, Xolair, Zonegran, Topamax and Myobloc.
- New Drugs that have not yet been considered for the ESI national formulary where there are no Generic/Brand equivalents but are approved by the U.S. Food and Drug Administration (FDA) for medical use.
- Drugs not included on the ESI national formulary and meeting any of the criteria listed above.

Provider Listings

A list of names, addresses and phone numbers of Plan pharmacies can be obtained from the Administrative Office or Express Scripts. The Administrative Office will send you a provider directory at no charge. You may call the Administrative Office toll free at **(800) 736-0401**. The directory may be sent directly to your residence. You may also contact Express Scripts directly at **(800) 206-4005** to request a provider listing or you may access provider listings on the Internet at www.express-scripts.com. Internet provider listings can be requested by the city, zip code or proximity to your home address. All of the above methods are free of charge.

Vision Benefits for Active Employees and Dependents

Vision benefits for Active Employees and Dependents are provided through a contract with Vision Service Plan (VSP).

Schedule of Benefits

This schedule lists the vision care services and materials to which you and your eligible Dependents are entitled, along with the applicable copayments for services and limits on the frequency of examinations and materials. A Member Doctor is someone who has contracted with VSP. A Non-Member Provider does not have a contract with VSP. The schedule includes Member and Non-Member benefits and copayments.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayment(s) as stated below. When Plan Benefits are available and received from Non-Member Providers, you are reimbursed for the benefits according to the schedule in the second column below less any applicable Copayment.

SCHEDULE OF VISION BENEFITS		
PLAN BENEFITS	MEMBER DOCTOR BENEFIT*	NON-MEMBER PROVIDER BENEFIT*
VISION CARE SERVICES Vision Exam	Covered in Full	Up to \$45.00
VISION CARE MATERIALS Lenses Single Vision Bifocal Trifocal Lenticular	Covered in Full Covered in Full Covered in Full Covered in Full	Up to \$45.00 Up to \$65.00 Up to \$85.00 Up to \$125.00
Frames	Covered up to Plan Allowance	Up to \$47.00
CONTACT LENSES Visually Necessary Professional Fees and Material	Covered in Full**	Up to \$210.00
ELECTIVE Professional Fees** and Materials	Covered up to \$120.00	Up to \$120.00
COPAYMENT	\$20	N/A
FREQUENCY Exam Lenses and Frames	Once every 12 months Once every 24 months	

*Less applicable copayment

**Additional discount applies to Member Doctor's usual and customary professional fees for contact lens evaluation and fitting.

Low Vision

Professional services, as necessary, for severe visual problems not corrected with regular lenses, including:

PLAN BENEFITS	MEMBER DOCTOR BENEFIT*	NON-MEMBER PROVIDER BENEFIT*
Supplemental Testing (Includes evaluation, diagnosis and prescription of vision aids, where indicated)	Covered in Full	Up to \$125.00
Supplemental Aids	Covered up to 75% of cost	Covered up to 75% of cost

*Less Applicable copayment

Maximum allowance for all Low Vision benefits of \$1,000 every two (2) years.

Selecting and Accessing a Plan Provider

When you desire to obtain Plan benefits from a Member Doctor, you should contact a Member Doctor or VSP. A list of names, addresses and phone numbers can be obtained from the Administrative Office or VSP. VSP can be contacted at **(800) 877-7195** or you can access provider information via the Internet at www.vsp.com.

If you are eligible for Plan benefits, VSP will provide benefit authorization directly to the Member Doctor. If you contact a Member Doctor directly, you must identify yourself as a VSP member so the doctor knows to obtain benefit authorization from VSP.

When such benefit authorization is provided by VSP and services are provided prior to the expiration date of the benefit authorization, this will constitute a claim against this Plan in spite of your termination of coverage or the termination of this Plan. Should you receive services from a Member Doctor without such benefit authorization or obtain services from a provider who is not a Member Doctor, you are responsible for payment in full to the provider.

Coverage for Out of Network Services

A Non-Member Provider is any Optometrist, Optician, and Ophthalmologist of other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.

If you are eligible for and obtain Plan benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by VSP in accordance with the

non-provider reimbursement schedule, less any applicable copayments. (See the section titled “Provisions/Procedures Governing Claims” for instructions on how to file claims for non-network providers).

Plan Conditions and Limits for Accessing Emergency Care

In emergency conditions, when immediate vision care of a medical nature such as bodily trauma or disease is necessary, Covered Persons can obtain services by contacting a Member Doctor (or out of network provider if your attached schedule of benefits indicates Covered Persons Plan includes such coverage). No prior approval from VSP is required for Covered Persons to obtain vision care for emergency conditions of a medical nature. However, services for medical conditions, including emergencies, are covered by VSP only under the Acute Eye Care and Primary Eye Care Plans. If coverage for one of these Plans is not indicated on your attached schedule of benefits or addendum, the Covered Person is not covered by VSP for medical services and should contact a Physician under the Covered Persons medical insurance Plan for care. For emergency conditions of a non-medical nature, such as lost, broken or stolen glasses, the Covered Person should contact VSP’s customer service department for assistance. They can be reached at **(800) 877-7195**.

Emergency vision care is subject to the same benefit frequencies, Plan allowances, copayments and exclusions as stated in the VSP summary of benefits. Reimbursements to Member Doctors will be made in accordance with their agreement with VSP.

Plan Provision that Require Pre-Authorization or Utilization Review to Access Care

Prior Authorization

Certain benefits require VSP’s prior authorization before such benefits are covered. VSP’s prior authorization determinations are based upon criteria developed by optometric and ophthalmic consultants and approved by VSP’s utilization management committee and board of directors.

- a. Initial Determination: VSP will approve or deny requests for prior authorization of services within fifteen (15) calendar days of the receipt of the request from the Covered Person’s doctor. In the event that a prior authorization cannot be resolved within the time indicated, VSP may, if necessary, extend the time for the decision by no more than fifteen (15) calendar days.
- b. Appeals: If VSP denies the doctor’s request for prior authorization, the doctor, Covered Person or the Covered Person’s authorized representative may request an appeal of the denial. Please refer to section on claim appeals for details on how to request an appeal.

Provisions/Procedures Governing Claims

If you are eligible for and obtain benefits from a Non-Member Provider, you should pay the provider his/her full fee. You will be reimbursed by VSP in accordance with the Non-Member Provider reimbursement schedule shown in your Plan booklet less any copayments. Reimbursements will be paid by submitting your receipts for eligible expenses to:

**Vision Service Plan
Attn: Out of Network Provider Claims
PO Box 997105
Sacramento, CA 95899-7105**

With the following information:

- an itemized receipt listing the services received,
- the Name, Address and Phone number of the Provider Seen,
- the Covered member's Identification Number,
- the Covered members Name Phone Number and Address,
- the Name of the Organization (Trust Fund) Providing VSP Coverage,
- the Patients Name, Date of Birth, Phone Number and Address, and
- the Patients relationship to the Covered Person (such as self, spouse or child).

Please keep a copy of the information and either fax the information to VSP at **(916) 851-5152** or mail it to the address listed above. Most out of network claims must be submitted to VSP within six months for reimbursement. However, certain plans may allow out of network claims to be submitted beyond the six month deadline. Please call VSP for exact timeframes.

You have the right to appeal any claim that has been denied in whole or in part. (Refer to page 80 for information the timing of claims appeals)

DENTAL PLAN OPTIONS

Active Employees are eligible for a choice of dental plans that are described in detail in separate booklets. The following Table compares the benefits under each of the dental plan options.

Benefit	Delta Preferred Option PPO Dental Plan			PMI **** Dental Plan
	DPO Dentist	Non-DPO Dentist	Non-Delta Dentist	
Use any dentist?	Yes	Yes	Yes	Selected Provider only
Calendar Year Deductible	\$50 per person/\$150 per family	\$100 per person; \$300 per family	\$100 per person; \$300 per family	None
Calendar Year Maximum	\$2,000 per person			None
Diagnostic and Preventive	100% not subject to Deductible	100% not subject to Deductible	90%	No Charge
Basic Benefits*	80% of DPO fee	80% of DPO fee	70% of DPO fee	Some copayments
Crowns, Jackets and other cast restorations	80% of DPO fee	80% of DPO fee	70% of DPO fee	Some copayments
Prosthodontics (bridges, partial dentures, full dentures)	80% of DPO fees (dentures subject to a maximum)	80% of DPO fees (dentures subject to a maximum)	70% of DPO fees (dentures subject to a maximum)	Some copayments
Orthodontics (dependent children only)	50% of DPO fees (\$1,500 lifetime maximum per person)	50% of DPO fees (\$1,500 lifetime maximum per person)	50% of DPO fees (\$1,500 lifetime maximum per person)	Up to a maximum payment of \$1,6000 to \$1,800 plus startup costs – children and adults
Out-of-Pocket Expense	Lowest copayments under Delta plan	Lower copayments under Delta plan	Highest copayments under Delta plan	Lowest copayment

* If you use a Delta DPO dentist, your out-of-pocket expense is the difference between the negotiated rate and the amount paid by Delta.

** If you use a Delta dentist who is not a DPO dentist, you will be responsible for the difference between the percentage payable by Delta of the amount negotiated for the procedure and the dentist's maximum negotiated rate for the procedure.

*** If you use a non-Delta dentist, you will be responsible for anything above the percentage payable by Delta and the dentist's charges for the procedure.

**** The lowest copayment is through the PMI dental plan but you must select a dentist and obtain all services from that dentist.

Request a copy of the Dental plan benefits booklets for review before selecting your dental plan. If you enroll in the PMI prepaid dental plan, you must select a dental office to receive all of your care.

A dental form is required for coverage. If you fail to return your enrollment form, YOU will not be eligible for benefits.

LIFE INSURANCE BENEFITS

(Provided by The Hartford)

This section provides you with a summary of the life insurance and accidental death and dismemberment benefits available to you. Complete information is available in the Certificate of Insurance issued by the Hartford which is available to you at no cost at the Administrative Office.

Life Insurance Benefits for Active Employees

The amount of your life insurance is \$11,000*. If you die from any cause while you are insured, the proceeds of the policy will be paid to your beneficiary.

* The amount of insurance reduces by 35% when you reach age 65 and by 50% when you reach age 70.

Beneficiary

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form. The change will be effective when the Fund Administrator receives the completed form. Beneficiary forms are available from the Fund Administrator.

If you name more than one beneficiary but you do not indicate how much each should get, the beneficiaries will be paid equal amounts. If you do not name a beneficiary, or if your beneficiary dies before you, the proceeds will be payable to the first of the following:

1. your surviving spouse or domestic partner;
2. your surviving children, in equal shares;
3. your surviving parents, in equal shares;
4. your surviving brothers and sisters, in equal shares;
5. your executors or administrators of your estate.

Waiver of Premium During a Total Disability

While you are insured, if you becomes totally disabled (unable to work in any occupation for wage or profit) before you reach age 60, your life insurance benefits will continue without premium payments. During any period of total disability, you will be required to submit proof of your continued disability at reasonable intervals but not more often than annually after you have been disabled for two years. Life insurance continued while you are totally disabled is subject to age reduction as if you were not disabled.

If you die during the period of total disability, benefits will be paid to your beneficiary if notice of claim is made within one year of the date of your death and the required proof is submitted to the insurance company.

Waiver of premium coverage will cease on the date you are no longer disabled. If you do not return to work in Covered Employment, you will be entitled to conversion privileges through the Hartford.

Accelerated Death Benefit – Life Insurance only

If you are diagnosed as being terminally ill and proof of the diagnosis is provided by an attending Physician licensed to practice in the United States, and you are less than 60 years of age, you may apply for a portion of your death benefit to be paid before your death. The amount you request may not be more than 80% of the face amount nor less than \$3,000. You may only exercise this option once. The term “terminally ill” means that you have a life expectancy of 6 months or less.

Receipt of an accelerated death benefit will reduce the amount payable to you beneficiary when you die.

Life Insurance Benefits for Dependents

Your Dependents are insured for the following amounts:

Spouse	\$5,000
Dependent Children:	
14 days to 6 months of age	\$100
6 months of age to age 19 (or to age 23 if a full-time student)	\$1,000

Beneficiary for Dependent's Life Insurance

The Employee is the beneficiary of his Dependent's life insurance. In the event the Employee predeceases the death of the Dependent, the beneficiary will be the executors or administrators of the Dependent's estate or the insurance company, may at its option pay to any of the following surviving relatives of the Dependent:

- a. mother and father;
- b. child or children;
- c. brothers or sisters.

Life Insurance Conversion Privilege for Employees and Dependents

If you or your Dependents are no longer eligible for group life coverage because you or they cease to belong to an eligible insured class or you terminate employment, you or they may convert the benefit to an individual policy issued by the insurance company. A medical examination is not required to obtain a converted life insurance policy. You will be charged a premium rate based upon your age at the time of conversion, the class of risk, and the amount of coverage selected.

Conversion is only available during the first 31 days following your termination of group coverage. If you die during this period, even if you have not elected conversion or paid for conversion, your beneficiary will be paid the amount of life insurance in force prior to your termination of employment.

You should contact the insurance carrier for more information about conversion options.

**ACCIDENTAL DEATH AND DISMEMBERMENT
BENEFITS FOR ACTIVE EMPLOYEES
(Provided by The Hartford)**

The Accidental Death and Dismemberment (AD&D) benefit covers loss due to an injury you sustain in an Accident that occurs while you are eligible. Dependents are not covered for Accidental Death and Dismemberment benefits.

Benefits

You are eligible for benefits for losses you sustain as a result of an accident. The loss must occur within 365 days of the date of the accident and must be the result of a bodily injury that is caused directly and exclusively by the accident. Proof of loss is required within 90 days of the loss. The Plan will not pay more than the \$11,000 for all covered losses from one Accident.

Schedule of Covered Losses and Benefits	
Loss*	Benefit
Life	\$11,000
Two hands	\$11,000
Two feet	\$11,000
Sight of two eyes	\$11,000
One hand and one foot	\$11,000
One hand and sight of one eye	\$11,000
One foot and sight of one eye	\$11,000
One hand or one foot	\$5,500
Sight of one eye	\$5,500
Loss of movement of three limbs or the loss of movement of both lower limbs	\$8,250
Loss of thumb and index finger on either hand, or loss or movement of one limb	\$2,750

* "Loss of hand or foot" means severance of the entire hand or foot at or above the wrist or ankle joint respectively.

"Loss of sight" means the total and irrecoverable loss of sight.

For loss of life, benefits will be paid to the beneficiary named for your life insurance coverage. For any other loss, the benefits will be paid to you. If you suffer more than one loss in any one accident, payment will be made for the lesser of \$11,000 or the sum of the losses.

Seat Belt/Air Bag Benefit

If you suffer a loss under the AD&D benefit while you are a passenger riding in or the licensed operator of an automobile and at the time of the accident, you were properly wearing a seat belt as verified on the police report, the Seat Belt Benefit will be payable in addition to the basic AD&D benefit. The Seat Belt Benefit payable will be \$1,100.

Air Bag Benefit

If you qualify for a Seat Belt Benefit and you were positioned in a seat that was equipped with a factory installed air bag, you were properly strapped in the seat belt when the air bag inflated, and the police report establishes that the air bag inflated properly upon impact, an additional \$550 will be payable.

The terms “air bag”, “Automobile,” “common carrier,” and “seat belt” have very specific definitions under the insurance contract. If you have a loss, you should request a copy of the definitions from the Administrative Office or the carrier.

Repatriation Benefit

If you die by accidental means and AD&D benefit becomes payable, an additional benefit may be payable if the death occurs outside the territorial limits of the state or country of your place of permanent residence. The amount of the benefit is the lesser of \$550 or the cost incurred for the preparation of your body for burial or cremation and the transportation of your body to the place of burial or cremation.

AD&D Exclusions

Benefits are not payable for any loss caused directly or indirectly, wholly or partly, by:

1. sickness;
2. disease;
3. any medical treatment for items (1) or (2);
4. any infection, except a pus-forming infection of an accidental cut or wound;
5. war or any act of war, whether war is declared or not;
6. any injury received while in any armed service of a country which is at war or engaged in armed conflict;
7. any intentionally self-inflicted injury, suicide, or suicide attempt, whether sane or insane;
8. taking drugs, sedatives, narcotics, barbiturates, amphetamines or hallucinogens unless prescribed for or administered by a licensed Physician; or
9. the injured person’s intoxication.

DEFINITIONS

When capitalized within, the following items shall have the meanings shown below.

Accidental Injury – Any accidental bodily injury which occurs while an individual is covered under the Plan and which is caused by external forces under unexpected circumstances and which does not arise out of or in the course of the employment of a Covered Person. Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

Ambulatory Surgical Center – Any public or private establishment which:

- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- has an organized medical staff of Physicians;
- has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
- does not provide services or other accommodations for patients to stay overnight.

An Ambulatory Surgical Center will not be covered if **(1)** its primary purpose is the performance of abortions or **(2)** it is maintained as an office by a Physician or Dentist for the practice of medicine or dentistry.

Birthing Center – A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility which:

- is in compliance with licensing and other legal requirements in the jurisdiction where it is located;
- is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;
- has organized facilities for birth services on its premises;
- provides birth services, which are performed by or under the direction of a Physician specializing in obstetrics and gynecology;
- has 24-hour-a-day registered nursing services; and
- maintains daily clinical records.

Calendar Year – The period of time commencing at 12:01 a.m. on February 1 of each year and ending at 12:01 a.m. on the next succeeding January 31. Each succeeding like period will be considered a new Calendar Year.

Charitable Research Hospital – a Hospital which:

- is internationally recognized as devoting itself primarily to medical research;
- expends not less than ten percent (10%) of its operating budget in each fiscal year exclusively on medical research activities, which are not directly related to the provision of services to patients;
- derives not less than one-third (1/3) of its gross revenues in each fiscal year from contributions, donation, grants, gifts, or other gratuitous forms from individuals, groups, persons, or entities unrelated to the Hospital. Contributions, donations, grants, gifts, or other gratuitous sources of revenue received as compensation for medical services provided to patients shall not be considered for these purposes;
- accepts patients without regard to the patient's ability to pay for medical services;
- admits not less than two-thirds (2/3) of its patients with a primary diagnosis or suspected disease or condition directly related to the specific area or areas in which the Hospital conducts research. However patients admitted because of an emergent life-threatening condition who could not be safely transported to another Hospital shall be covered as any other illness.

Claimant – Any Covered Person on whose behalf a claim is submitted for benefits under the Plan.

Contract Provider – A physician, hospital, x-ray or laboratory facility that has a contract with the Preferred Provider organization with which the Trust has a contract.

Convalescent Hospital – see "Skilled Nursing Facility"

Covered Person – An Employee or Dependent meeting all eligibility requirements and properly enrolled in the Plan.

Deductible – The amount of Covered Medical Expenses that must be paid by the Covered Person before Plan payments begin. .

Home Health Care Agency – An agency or organization which:

- is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;
- has policies established by a professional group associated with the agency or organization which includes at least one registered graduate nurse (R.N.) to govern the services provided;

- provides for a full-time supervision of such services by a Physician or by a registered graduate nurse;
- maintains a complete medical record on each patient;
- has a full-time Administrator
- In rural areas where there are no agencies, which meet the above requirements, or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice – An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional setting for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel, which includes at least one Physician and one registered graduate nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital – An institution which:

- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- is primarily engaged in providing medical treatment to sick and injured persons as registered bed patients and maintains permanent facilities for five or more patients;
- is operated under the supervision of a staff of Physicians;
- continuously provides 24-hour-a-day nursing service by registered graduate nurses;
- maintains a daily medical record for each patient;
- maintains facilities for diagnosis of injury or disease;
- maintains permanent facilities for major surgical operations on its premises; and
- is not, other than incidentally, a place of rest, for custodial care, for the aged, for drug addicts or alcoholics, for the care of senile persons, a nursing home, a hotel, a school, a residential treatment center, or a similar institution.
- The definition of Hospital shall be expanded to include a psychiatric health facility as defined in Section 1250.2 of the Health and Safety Code of the State of California.

Inpatient – A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) which is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), or Intermediate Care Unit – A Hospital or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, which provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and which is separated from the rest of the Hospital's facilities.

Medically Necessary – Medically Necessary treatment which is:

- consistent with approved and generally accepted medical and surgical practice for the Illness, Injury, or condition of the patient prevailing in the geographic locality where and at the time the service or supply is rendered. Determination of approved and generally accepted practice is determined through consultation with appropriate authoritative medical, surgical, or dental practitioners;
- ordered by the attending or other licensed Physician; and
- not primarily for the convenience of the patient, caregiver or provider. Any confinement, operation, treatment or service that is not a valid course of treatment recognized by an established medical society in the United States is not considered Medically Necessary treatment.
- No treatment or service, or expense in connection therewith, which is experimental or investigational in nature, is considered Medically Necessary treatment.

Medicare – Health Insurance for the Aged as established by Title I of Public Law 89-99 including parts A & B and Title XVIII of the Social Security Act, as amended from time to time.

Non-Contract Provider – A physician, hospital, x-ray or laboratory facility that does not have a contract with the Preferred Provider organization with which the Trust has a contract.

Outpatient – Services rendered on other than an Inpatient basis or services rendered at a covered non-Hospital facility.

Physician – A legally licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) and any other licensed health care provider that the law requires be recognized as a Physician, who is practicing within the scope of his license. The term "Physician" does not include interns, residents, fellows or others enrolled in a residency training program. Also, for purposes of certifying Total Disability, a Physician will include ONLY a M.D. or a D.O.

Preferred Provider Organization (PPO) – A selected group of providers who have contracted with the Health Plan to provide health care services to Covered Persons at specific rates. See the benefit schedules of the Health Care Coverage(s) for special benefit levels that may apply to services obtained from contract providers.

Pregnancy – Childbirth, miscarriage or complications arising there from.

Rehabilitation Center – A facility which is designed to provide therapeutic and restorative services to sick or injured persons and which:

- carries out its stated purpose under all relevant state and local laws; or
- is accredited for its stated purpose by either the Joint Commission for Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities; or
- is approved for its stated purpose by Medicare.

Semi-Private Room Charge – The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 70% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

Sickness – Sickness shall mean bodily illness or disease (other than mental health conditions), and congenital abnormalities of a covered newborn child. Also, a condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

Skilled Nursing Facility – An institution which:

- is duly licensed as a Convalescent Hospital, extended care facility, Skilled Nursing Facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;
- is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons;
- is under the full-time supervision of a Physician or a registered graduate nurse;
- admits patients only upon the recommendation of a Physician (other than the patient's own Physician), maintains complete medical records, and has available at all times the services of a Physician;
- has established methods and Procedures for the dispensing and administering of drugs;
- has an effective Utilization Review plan;
- is approved and licensed by Medicare;
- has a written transfer agreement in effect with one or more Hospitals; and
- is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Urgent Care Facility – A freestanding facility, which is engaged primarily in providing minor emergency and episodic medical care and which has:

- a board-certified Physician, a registered nurse (R.N.) and a registered x-ray technician in attendance at all times;
- has x-ray and laboratory equipment and a life support system.
- An Urgent Care Facility does not include a clinic located at, operated in conjunction with, or in any way made a part of a regular Hospital.

Usual and Customary Charge – For any service or supply, the Usual and Customary Charge will not exceed:

- the amount customarily charged by the provider for the service or supply; or
- The charge for the service or supply made by providers of comparable services or supplies in the same locality.

A special provision will apply when there are no providers of comparable services or supplies in the same locality, or the event of an unusual type of service or supply. When this happens, the Plan will determine whether the charge is appropriate, based on:

- the complexity involved;
- the degree of professional skill required;
- the cost of supplies; and
- other pertinent factors.

The Plan may decline to pay flat rate charges when procedures, fees and/or time involved are not itemized.

For purposes of this Plan, Usual and Customary for non-plan providers will not exceed the product of the following and the unit value in the applicable Health Insurance Association of America (HIAA) Value Scale:

Medical	80 th percentile	2004 HIAA
Surgical	80 th percentile	2004 HIAA
Anesthesia	80 th Percentile	2004 HIAA
Lab	80 th Percentile	2004 HIAA
X-ray	80 th Percentile	2004 HIAA

NOTE: With regard to charges made by a provider of services participating in the Plan's PPO program, Usual and Customary shall mean the rates negotiated between the provider and the Beech Street Provider Network.

GENERAL HEALTH CARE COVERAGE EXCLUSIONS

The following exclusions apply to all health benefits and no benefits shall be payable under these Health Care Coverages for:

Court-Ordered Confinement – Any confinement of a Covered Person in a public or private institution as the result of a court order.

Criminal Activities – Any injury resulting from or occurring during the Covered Person's commission or attempting to commit an aggravated assault or felony, or any injury resulting from a Covered Person being involved in illegal activities or an illegal occupation EXCEPT that this exclusion will not include those actions which are deemed criminal actions in accordance with California Vehicle Codes Sections 23152 and 23153.

Drugs in Testing Phases – Medicines or drugs which are in the Food and Drug Administration Phases I, II, or III testing.

Excess Charges – Charges in excess of the Usual and Customary Charges for services or supplies provided.

Experimental Procedures – Services or supplies which are specifically listed by the American Medical Association as having no medical value or which are considered experimental or investigative in nature as determined by the Food and Drug Administration and the American Medical Association's Council on Medical Specialty Societies or treatments, which are not a part of generally accepted health care services.

Fertility Drugs – Fertility drugs are not covered under the Health Plan or the prescription drug program.

Forms Completion – Charges made for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities – Services furnished to the Covered Person in any veterans Hospital, military Hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such government, for which the Covered Person has no legal obligation to pay.

Late-Filed Claims – Claims which are not filed with the Administrative Office for handling within the required time periods as included in the **Benefit Claim and Appeal Procedures** section on page 79.

Military Service – Charges for treatment of any injury sustained or illness contracted while in the military service of any country.

Missed Appointments – Expenses incurred for failure to keep a scheduled appointment.

No Charge / No Legal Requirement to Pay – Service for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. This exclusion does not apply to services rendered by a Charitable Research Hospital, as defined herein, or to benefits or coverage which is available through the Medical Assistance Act (Medicaid) (see page 69).

Other Coverage – Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to be reimbursed by or furnished by any plan, authority or law of any government, or governmental agency (Federal or State, Dominion or Province or any political subdivision thereof), except as noted under Notice to Participants Eligible for Medicare 'A' and 'B' and Notice to Participants/Dependents Entitled to Medicaid or under the Plan's "Subrogation" provisions found on page 76.

Outside United States – Charges incurred outside of the United States if the Covered Person traveled to such a location for the sole purpose of obtaining such services, drugs or supplies.

Prior Coverages – Services or supplies for which the Covered Person is eligible for benefits under the plan which this Plan replaces.

Relative or Resident Care – Any service rendered to a Covered Person by a relative (i.e. a spouse, or a parent, brother, sister, child, or child of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Sexual Dysfunction – Expenses incurred in the purchase of any sexual dysfunction drug or device.

Shipping and Handling – Any charges for shipping, handling or postage, or interest or financing charges.

Telecommunications – Advice or consultation given by or through any form of telecommunication.

Third Party Injuries and Exclusions – This Plan does not provide benefits where the care required is for injuries to you or your eligible dependents caused through the act or omission of another person or entity, known as the Third Party, and where a claim or lawsuit for damages is being pursued against the Third Party.

Travel – Travel, whether or not recommended by a Physician.

Uninsured Motorist Coverage – Expenses which would be covered by personal injury protection benefits under an automobile insurance policy, if you are able to, or are

entitled to, recover these benefits from your policy. Examples include medical payments insurance, uninsured motorist coverage, etc.

Veterans Hospital – see "Government-Operated Facilities".

War or Active Duty – Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications there from, or service in the armed forces of any country.

Work-Related Conditions – Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose including any recovery pursuant to a disputed settlement (or a "Thomas" finding).

Miscellaneous

Notice to Participant(s) Eligible for Medicare "A" and "B"

In accordance with the Tax Equity Fiscal Responsibility Act of 1982 (TEFRA – P.L. 97-248) and the Deficit Reduction Act of 1984 (DEFRA – P.L. 98-369), an active Employee or spouse, who has attained age 65 and is eligible for Medicare, may elect or reject in writing medical coverage under This Plan. If such person continues medical coverage under This Plan, the benefits of This Plan shall generally be determined before any benefits provided by Medicare (i.e., This Plan will pay its benefits first and then the claims may be submitted to Medicare for consideration). Covered Persons should be certain to enroll in Medicare coverage in a timely manner to ensure maximum coverage. If a person elects to have Medicare as his primary coverage, he must terminate participation in this Plan.

There may be an instance when, in accordance with Federal Law, this Plan may assume a secondary position to Medicare (i.e., Medicare will determine its liability first). If this should occur, this Plan reserves the right to assume the secondary carrier position and benefits will be determined in accordance with the **Coordination of Benefits** provision above. When This Plan may lawfully assume a secondary position and an Employee or Dependent becomes eligible for the program of benefits provided under Medicare, he is deemed to be covered by both Medicare parts "A" and "B" for all purposes under This Plan. An Employee or Dependent is considered to be covered by Medicare on the earliest date any coverage under Medicare could have been effective to him had he applied for Medicare in a timely manner.

NOTE: If a Medicare-eligible Employee rejects coverage under the Plan, no Plan coverage will be available as secondary coverage for him and no coverage at all will be available for his Dependents.

Notice to Participant(s) Eligible for Medicaid

In accordance with the Omnibus Budget Reconciliation Act of 1993, the Plan must provide primary coverage for active employees, their spouses and other dependents covered under the Plan with state Medicaid programs providing secondary coverage. This means that in enrolling an employee, his spouse or dependents, or in determining or making payment for benefits for these employees and their eligible dependents, the Plan cannot take into account that these individuals are also covered by a state Medicaid program.

The Plan will honor any assignment of rights made by or on behalf of such employees and their eligible dependents as required by a state Medicaid program. The Plan will also honor any state acquired rights from third parties. The Plan in these instances will reimburse any state Medicaid program if payment was made by such state program and the Plan should have been responsible for the payment of the medical services. The state Medicaid program will be reimbursed in accordance with the terms and conditions of the Plan.

Amendment and Termination

In order that the Fund may carry out its obligation to maintain within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Fund participants, the Board of Trustees expressly reserves the right, in its sole discretion at any time and from time to time, to change the eligibility rules, reduce the benefits or otherwise amend the Plan, or terminate it in its entirety, as may be required by the circumstances.

HOW TO FILE A CLAIM

This section explains the steps you or your authorized representative must follow to file a claim. You may appoint an authorized representative to act on your behalf in filing a claim or pursuing an appeal of an adverse decision. If you wish to appoint a representative, you must provide the Plan Administrative Office with a signed written letter of authorization appointing your representative. You will be required to provide the Plan Administrative Office with all the information required to process your claims. This may require the completion of a claim form and, for claims involving an accident, you may also be required to complete an accident report form.

File Claims Promptly

Your claim should be filed as soon as possible. If your claim is filed later than 12 months after its original occurrence, the Plan must deny benefits. File all of your claims promptly to obtain the benefits you are entitled to.

Where to Get Claim Forms

The Claim Form and your itemized provider's statements will *usually* furnish all of the information needed to pay your benefits. If an additional form is required for some special reason, the Administrative Office will send one to you. You may get the form you need from:

**Riverside County Electrical Health and Welfare Trust Fund
2831 Camino Del Rio South, Suite 311
San Diego, CA 92108
(800) 736-0401**

Claim Forms for Accidental Death and Dismemberment Only

When the Administrative Office receives the notice of claim, the forms for filing proof of loss will be sent to the Claimant. If these forms are not sent to the Claimant within 15 days, the Claimant will have met the proof of loss requirements by giving the insurance carrier a written statement of the occurrence, nature and extent of the loss within the time limit as stated in the proof of loss section.

Life Insurance or Accidental Death and Dismemberment Benefits

In the event of death a copy of the death certificate must be sent to the Plan Office as soon as possible. The Administrative Office will advise you or your beneficiary if additional documentation is required. The insurance company will process the claim and make payment to you or your beneficiary in accordance with the provisions of the contract.

If your claim is for dismemberment benefits, you should contact the Administrative Office for instruction and a claim form. Once the documentation is completed, the insurance company will process your claims and make payment to you under the terms of their contract.

Notice of Claim (Applies to Accidental Death and Dismemberment Only)

Written notice of claim must be given to the Administrative Office within 90 days after a covered loss occurs, or as soon as reasonably possible after the start of the covered loss. The notice should include the Group Contract Number, the Certificate Number and the name of the Plan, the insured active Employee and if applicable, the insured Dependent.

If it was not reasonably possible to give the notice in the time period, the Company will not reduce or deny any claim for this reason, if the notice is filed as soon as reasonably possible.

Proof of Loss (Applies to Accidental Death and Dismemberment Only)

The Company must be given written proof of loss within 90 days after the loss. If it was not reasonably possible to give this proof in the time required, the Company will not reduce or deny any claim for this reason, if the proof is filed as soon as reasonably possible.

Workers' Compensation Not Affected (Applies to Accidental Death and Dismemberment Only)

The Contract is not issued in lieu of, nor does it affect any requirement for, coverage by any Workers' Compensation Law, Occupational Disease Law or similar laws.

Assignment of Contract

The Plan cannot assign the Contract.

Comprehensive Medical, Dental and Vision Benefits

The payment of claims for comprehensive medical expense, dental and vision benefits are subject to the Coordination of Benefits rules. (Refer to page 72 for details)

Indemnity Medical Plan

Hospital claims will generally be submitted directly to Beech Street by the hospital. However, in the event you receive such a claim, submit it to the Administrative Office and they will make certain it gets sent to the proper party.

A properly completed medical claim must be submitted to the Administrative Office before any benefits can be paid. Be sure you have completed the section of the Statement of Medical Claim form headed "Part I – To Be Completed By The Member." Most Hospitals and Physicians' offices submit standard billing forms and may request one of your claim forms. However, it is still your responsibility to submit the medical claim form to the Administrative Office.

If you or your eligible Dependent has received medical treatment:

1. Obtain a Statement of Medical Claim form from the Administrative Office.
2. Complete Part I and submit the form to your medical provider for completion.
3. Submit all completed forms with and itemized billing to the Administrative Office at:

**Riverside County Electrical Health and Welfare Trust Fund
2831 Camino Del Rio South, Suite 311
San Diego, CA 92108
(800) 736-0401**

A Covered Person may be denied benefits as a result of the failure of the Covered Person to file a claim for benefits within 90 days following the date of loss, or within one year of the date he or she incurred the expense for which benefits are payable, if it was not reasonably possible to file within the 90 day filing period.

If your claim is denied in whole or in part, you have the right to appeal the decision. (refer to page 79 for details)

How to File a Dental Claim

Refer to the dental booklet for information on filing claims under Delta or PMI.

How to File a Vision Claim

Refer to page 72 for information on filing vision claims if you use a non-participating vision provider.

HMOs, Pre-Paid Plans, and Fully Insured Plans

The Aetna and Kaiser pre-paid medical plans are fully insured and have their own claims procedures. You should refer to the benefit booklet that describes the specific instructions for filing claims.

Benefits Unpaid at Death – Incompetency

Benefits may be payable to any person or institution entitled to such payment, as much as \$500 of any benefits, that:

- are to be paid at the time of your death; or
- are to be paid to a minor who is not able to execute a valid release, and for whom no guardian has been appointed.

To the extent of the payment, the Fund Administrator will have no more liability under the group Plan.

Physical Examination and Autopsy

The Fund Administrator shall have the right and opportunity to order the examination of Participant by a Physician of its choice, to determine the extent of any Sickness or injury for which a claim is made. This right may be used as often as it is reasonable to do so. If a Participant dies, an autopsy may be required (where the law does not forbid it). Such an examination or autopsy shall be made at the expense of the Fund Administrator.

Coordination of Benefits (COB)

Applicability

This Coordination of Benefits (COB) provision applies to all medical and dental benefits under this Plan when you or your eligible dependent has health care coverage under more than one Plan. The terms "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

- will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
- may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first.

Definitions

1. A "Plan" is any of these which provides benefits or services for medical care or treatment:
 - a. group, blanket or franchise insurance coverage;
 - b. service plan contracts, group practice, individual practice and other prepayment coverage;
 - c. labor-management trustee plans, union welfare plans or employee benefit organization plans;
 - d. any coverage under governmental programs, (except coverage under Medical) and any coverage required or provided by any statute, including Medicare.

Each contract or other arrangement for coverage under a. or b. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. "This Plan" is your Group Medical Plan described in this booklet.
3. "Primary Plan/Secondary Plan." The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. "Allowable Expense" means the expense for Medically Necessary health care covered under This Plan, not to exceed the contracted rate for a PPO provider or the Plan's Usual and Customary rate for a non-PPO provider.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered a benefit paid.

5. "Claim Determination Period" means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan, which has its benefits determined after those of the other Plan, unless:

- The other Plan has rules coordinating its benefits with those of This Plan; and
- both those rules and This Plan's rules, as described below, require that This Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan, which covers the person as an employee member, or subscriber (that is other than as a dependent) are determined before those of the Plan which covers the person as a dependent.
2. The Birthday Rule. The Plan of the parent whose birthday occurs earlier in the year pays first (year of birth is not taken into account); the other Plan pays second. (Example: John is born in March Mary in June. John's Plan pays first.) If both parents have the same birthday the Plan of the person who has been covered longer pays first.
3. Dependent Child of Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents benefits for the child are determined in this order:
 - a. If there is a court decree whereby one parent is responsible for the health care expense of the child, the expenses are paid according to the decree.
 - b. If there is no decree or the decree is silent the Plan of the parent with custody pays first; the spouse of the parent with custody pays second; and the Plan of the parent without custody pays last.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Active/Inactive Employee. The benefits of a Plan that covers a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The benefits of a Plan which covers a person as a dependent of an employee who is neither laid off or retired are determined before those of a Plan which covers that person as a dependent of a laid off or retired employee. If the other Plan does not have this rule, and if, as a result, the Plan does not agree on the order of benefits, this rule is ignored.
5. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan, which covers an employee, member or dependent longer are determined before those of the Plan which covered that person for the shorter time.

Effect on the Benefits of this Plan

This section applies when in accordance with the order of benefit determination rules, This Plan is a Secondary Plan to one or more other Plans. In that event the benefits of This Plan may be reduced under this section.

The benefits of This Plan will be reduced when the sum of:

- the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
- the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made,

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limitation of This Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. The Administrative Office has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Administrative Office need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Administrative Office any facts it needs to determine This Plan's coverage.

Facility of Payment

A payment made under another Plan may include an amount, which should have been paid under This Plan. If it does, the Administrative Office may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Administrative Office will not have to pay that amount again. The term "payment made" includes providing benefits in the form of service, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Administrative Office is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- the persons it has paid or for whom it has paid;
- insurance companies; or
- other organizations.

Whenever payments have been made by the Fund for services or supplies for the benefits of a person who was not an Eligible individual at the time such services or supplies were rendered, the Fund shall have the right to recover such payments from among one or more of the following, as the Fund shall determine:

- the persons to or for or with respect to whom such payments were made; or
- the person who benefited from such payments, or his legal guardian.

The "amount of the payments made" includes the reasonable cash value of any benefit provided in the form of services.

Third Party Claims/Subrogation

If a participant or the participant's eligible dependents are entitled to receive benefits from this Plan for injuries caused by a third party or as a result of any accident, or if a participant or the participant's eligible dependents receive an overpayment from this

Plan, this Plan has the right of subrogation or full reimbursement for all costs and benefits paid or incurred, or which will be incurred in the future, when any claim for benefits is filed on a participant's or a participant's eligible dependents' behalf where the event(s) that caused the claim are or may be the fault of, or the claim may be payable by, any other party, including, but not limited to Workers' Compensation, an insurance policy (including uninsured or under-insured provisions in an insurance policy), another benefit plan, or any party that may be responsible for the event(s) related to the claim. As such, this Plan has the right to obtain full restitution of the benefits paid by this Plan from:

- any full or partial payment which an insurance carrier makes (or is obligated or liable to make) to the participant or the participant's eligible dependents;
- the participant or the participant's eligible dependents, if any full or partial payments are made to the participant or the participant's eligible dependents by any party, including an insurance carrier, in connection with, but not limited to, the participant, the participant's eligible dependents, or a third party's;
- Worker's Compensation coverage;
- automobile liability coverage;
- uninsured motorist coverage;
- under-insured motorist coverage;
- homeowner's coverage; or
- other insurance coverage.

With respect to benefits which this Plan paid on behalf of the participant or the participant's eligible dependents, this Plan has the right to full restitution from any payment received by the participant or the participant's eligible dependents from any third party whether or not the payment separately allocated an amount to the restitution of the expenses or types of expenses covered by this Plan or the benefits provided under this Plan. Any payment received by the participant or the participant's eligible dependents from a third party must be deposited in a separately identified bank account as mutually agreed upon by the participant or the participant's eligible dependents and this Plan. Only payments received from such recovery or recoveries shall be deposited in this separate bank account and no monies shall be withdrawn from such account without express written acknowledgment and authorization from this Plan's Fund Administrator. Any payment received by the participant or the participant's eligible dependents is subject to a constructive trust. Any third-party payment received by the participant or the participant's eligible dependents must be used first to provide restitution to this Plan to the full extent of the benefits paid or payable under this Plan.

This Plan does not recognize the Make-Whole Doctrine. This Plan is entitled to obtain restitution of any amounts owed to it either from third-party funds received by the participant or the participant's eligible dependents, regardless of whether the participant or the participant's eligible dependents have been made whole for losses sustained at the hands of the third party.

This Plan expressly rejects the Common Fund Doctrine with respect to payment of attorney's fees. A plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise this Plan's equitable (or other) right to obtain full restitution.

The participant and the participant's eligible dependents are also required to do the following:

- Notify this Plan's Fund Administrator as soon as possible and in writing that this Plan may have an equitable (or other) right to obtain restitution of any an all benefits paid by this Plan;
- Inform this Plan of any payments received;
- Inform this Plan's Fund Administrator in advance of any trial dates of settlement proposals advanced or agreed to by a third party or a third party's insurer;
- Provide this Plan's Fund Administrator with all information requested regarding an action against a third party, including an insurance carrier;
- Fully cooperate with this Plan's Fund Administrator in all respects in this Plan's enforcement of its equitable (or other) rights to restitution, including execution of the Subrogation Agreement;
- Not settle, without prior written consent of this Plan's Fund Administrator, any claim that the participant of the participant's eligible dependents may have against a third party, including an insurance carrier; and
- Take all other action as may be necessary to protect the interests of this Plan.

In the event a participant or the participant's eligible dependents do not comply with the requirements of this section, this Plan may deny benefits to the participant or the participant's eligible dependents by the amount of benefits paid by this Plan. This right of offset shall not limit the equitable (or other) rights of this Plan to recover such monies in any other manner.

CLAIMS REVIEW AND APPEALS PROCEDURES

Benefit Claim and Appeal Procedures

The Indemnity Medical Plan benefits provided to you and your eligible dependents which are fully described in this booklet will only be available if you comply with the procedures set forth below.

Administrative Review

Pre-Service Claims

A pre-service claim for medical care is a claim that the Plan requires an approval in advance of obtaining medical care. The Plan requires pre-authorizations for medical care to determine whether a hospital stay is Medically Necessary. Alicare Medical Management will make the determination of Medically Necessity.

Claims must be made to Alicare Medical Management at **(800) 274-7767** for hospital stay medical necessity determinations. Written requests should be addressed to Alicare Medical Management, 8C Industrial Way Salem, NH 03079.

A predetermination may also be required for certain medications under the pharmacy benefit and for certain vision services. Refer to pages 45 and 49 for details.

Urgent Care Claims

An urgent care claim for medical care is one that must be resolved more quickly than within the time periods for non-urgent care claims because if it is not so resolved it could: a) seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or b) would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is a claim for urgent care is to be determined by Alicare Medical Management applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Additionally, a claim will be considered an urgent care claim if a physician with knowledge of the claimant's medical condition states that it is a claim involving urgent care.

There is no requirement that you obtain pre-approval of an urgent or non-urgent claim, except for medical necessity for a hospital stay.

Benefit Claim Procedures for Pre-Service Urgent Care Claims

Urgent care claims may be made orally or in writing by you, your physician or other authorized representative. Urgent care claims must be made to Alicare Medical Management at **(800) 274-7767** for hospital stay medical necessity determinations. Written requests should be addressed to Alicare Medical Management, 8C Industrial Way Salem, NH 03079.

All claims must identify the name of the claimant; the specific medical condition or symptom; and the specific treatment, service, or product for which approval is sought. Alicare Medical Management will notify you of its decision within 72 hours of receipt of the claim. You and Alicare Medical Management may agree to an extension of this time period, but Alicare Medical Management may not unilaterally extend same. Notification may be oral; unless written notification is requested by you or your authorized representative. Any oral notification by Alicare Medical Management will be followed up in writing within three days by U.S. mail, facsimile transmission or other electronic means.

Incomplete Claims

If you or your authorized representative fails to follow the above-described procedures or does not provide sufficient information to decide a claim, Alicare Medical Management will notify you within 24 hours of the failure and inform you of the information necessary to file a complete claim. You will have a reasonable amount of time (at least 48 hours) to supply the additional information. When your complete claim is filed with Alicare Medical Management, you will be notified of its determination, whether adverse or not, as soon as possible, but not later than 48 hours after the earlier of their receipt of the specified information or the end of the period afforded you to provide the additional information. You and Alicare Medical Management may agree to further extensions of these time periods.

Non-Urgent Care Claims

A non-urgent care claim for medical care is a claim that is not an urgent care claim.

Benefit Claim Procedures for Pre-Service Non-Urgent Care Claims

Non-urgent care claims will be handled in a similar manner as urgent care claims except that after filing a non-urgent care claim, Alicare Medical Management will notify you in writing of the decision no later than 15 days from the date the claim is filed with Alicare Medical Management. This period may be extended for an additional 15 days if prior to the expiration of the initial 15-day period you are notified of the circumstances requiring the extension of time and the date by which Alicare Medical Management expects to

render a decision. You and Alicare Medical Management may agree to further extensions of these time periods.

Incomplete Claims

If you or your authorized representative fail to follow the above-described procedures or do not provide sufficient information to decide a claim, Alicare Medical Management will notify you as soon as possible but no later than the end of the initial 15-day period. You will have 45 days from the receipt of the notice within which to provide that information. You and Alicare Medical Management may agree to further extensions of this time period. The time periods for deciding such a claim shall be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Benefit Coverage

The Plan does not require pre-approval of claims for benefit coverages before medical care is received for either urgent or non-urgent claims (e.g., whether experimental treatment is covered). Preauthorization does, however, apply to hospitalizations (see page 30). However, this does not mean the Plan will pay for the medical expenses incurred when the billing is actually received. There are cost-sharing arrangements and other limitations and exclusions under the Plan that must be taken into consideration.

Notwithstanding, for convenience purposes only, if you and/or your medical provider has any questions regarding benefit coverage issues, you may request, in writing, a Plan determination by sending your request to the Administrative Office at 2831 Camino del Rio South, Suite 311 San Diego, CA 92108. The Administrative Office will respond within a reasonable time period. No such request will be viewed as a “claim for benefits” as defined in the DOL claims procedure regulations. Please note the Plan cannot tell you or the medical provider the specific amount payable under the Plan until it receives the appropriate medical claim form and reviews the actual request for payment.

Concurrent Care Claims

A concurrent care claim is a claim for continued treatment that has been provided over a period of time or number of treatments which was previously approved but you have been notified that the Plan continuation of treatment will be reduced or terminated. The Plan will not reduce or terminate treatment previously approved as Medically Necessary. Therefore, there can be no concurrent claims.

Post-Service Claims

A post-service claim is a claim for a benefit under the Plan that is not a pre-service claim

(e.g., treatment has been rendered or a service performed and you are requesting payment for the treatment or services under that Plan). Post-service claims include requests for actual payment by the Plan of any pre-service claim. If you file a post-service claim, the Administrative Office will notify you of its decision within 30 days of the receipt of the claim. The Plan is allowed one 15-day maximum extension if the claim decision cannot be made for reasons beyond the control of the Plan and the Administrative Office notifies you prior to the expiration of the initial 30-day period, explains the circumstances for the extension, and identifies the date it expects to render a decision. You and the Administrative Office may agree to further extensions of these time periods.

Benefit Claim Procedures for Post-Service Claims

A post-service claim for medical care must be filed with the Administrative Office in accordance with the following procedures before any benefits can be paid:

If you or your eligible dependent received medical treatment, you must:

1. Obtain a claim form from your union, employer or the Administrative Office;
2. Complete Part I of the claim form;
3. Submit the form to your medical provider for completion of Part II (or for attachment of an itemized billing); and
4. Provide the form along with itemized billings to the Administrative Office at:

**Riverside County Electrical Health and Welfare Trust Fund
2831 Camino Del Rio South, Suite 311
San Diego, CA 92108
(800) 736-0401**

Post-service claims must be submitted no more than 90 days after your visit. If filing a claim is delayed through no fault of yours, the Fund may consider the claim if it is submitted within one year after the date of service. No benefits will be payable if a post-service claim is submitted after one year from the date of service.

Incomplete Claims

If you fail to follow the above procedures or do not provide sufficient information to decide a claim, the Administrative Office will notify you within 30 days of the failure and inform you what is required to file a complete claim. You will have at least 45 days from receipt of the notice within which to provide that specified information. You and the Administrative Office may agree to further extensions of this time period. The time period for deciding a post-service claim shall be tolled from the date on which

notification of the extension is sent to you until the date you respond to the request for additional information.

Notice of Claims Denial

If any claim (pre-service or post-service) is denied in whole or in part on the basis of eligibility or that the benefits will not be paid under the Plan because they are not Medically Necessary or not covered, you will be provided with a notice of denial/adverse benefit determination which will contain:

1. the specific reason or reasons for the denial;
2. reference to the specific Plan provision(s) on which the denial is based;
3. a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
4. an explanation of the Appeal Procedures and time limits applicable to such procedures, including a statement of your right to file a civil action under Section 502(a) of ERISA following the exhaustion of the Appeal Procedures (see below);
5. in the case of a denial a statement that:
 - a. if an internal rule, guideline, protocol or other similar criterion was relied upon in the denial, then the internal rule, guideline, protocol or other criterion will be provided free of charge to you upon request; or
 - b. If the denial was based on medical necessity or experimental treatment or similar exclusion or limit then the explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided to you free of charge upon request.
6. In the case of a pre-service urgent care claim, a description of the expedited appeal review process available for such a claim.

Appeal Procedures

These appeal procedures shall be the exclusive procedures available to any employee or beneficiary who is dissatisfied with an eligibility determination; benefit award or who is otherwise adversely affected by an action of the Trustees. These procedures must be exhausted before you (“Claimant”) may file suit under Section 502(a) of ERISA. The Claimant may request an appeal within 180 days of receipt of a claim denial. Aicare Medical Management and/or the Administrative Office, as applicable, shall provide

access to and copies of documents, records and other information free of charge that are relevant to the claim, upon receipt by the Claimant. Claimant will have the opportunity to submit written comments, documents, records or any other information in support of the appeal.

Pre-Service Claims

A Claimant may file a request for an appeal of any Aicare Medical Management pre-service medical necessity decision. There are two types of pre-service appeals: urgent and non-urgent. Pre-service claim denials are subject to one level of mandatory appeal to Aicare Medical Management.

Appeal Procedures for Pre-Service Urgent Care Claims

Claimant may file a request for an expedited urgent care appeal to Aicare Medical Management either orally or in writing at **(800) 274-7767** or Aicare Medical Management, 8C Industrial Way Salem, NH 03079. Information transmitted between Aicare Medical Management and Claimant shall be by telephone, facsimile transmission or other expeditious means. Claimant will be notified of the appeal decision, whether adverse or not, as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the request for an appeal. If the notification is made orally, a written decision will also be provided within 3 days. You and Aicare Medical Management may agree to further extensions of these time periods.

Appeal Procedures for Non-Urgent Care Claims

Claimant may file a request for a non-urgent care appeal in writing to Aicare Medical Management, 8C Industrial Way Salem, NH 03079. Claimant will be notified of the appeal decision, whether adverse or not, no later than 30 days after receipt of the written appeal.

Benefit Coverage

There are no appeals of pre-service benefit coverage decisions since the Plan does not require pre-approval of benefit coverage. However, if you requested a coverage determination as described above, you may appeal an adverse benefit coverage determination. Notwithstanding, such a request is not covered by the DOL regulations, including any time frame restrictions within which an appeal must take place.

Post-Service Claims

Appeal Procedures for Post-Service Claims

Claimants may file a request for an appeal of any post-service claim denial. Post-service claim denials are subject to mandatory appeal procedures as follows:

The appeal will be heard by written submission no later than the Board of Trustees' quarterly meeting that immediately follows the receipt of a request for appeal except if the request for an appeal is filed within 30 days of the date of the meeting. In such a case, an appeal decision will be made no later than the date of the second meeting following the Plan's receipt of the Claimant's request.

If there are special circumstances, the appeal will be heard and decided no later than the third meeting date following the Plan's receipt of the request for an appeal. If such an extension is required, the Claimant will be provided with notice in advance of the extension that will describe the special circumstances and identify the date the appeal will be heard and decided.

Claimant will be notified of all post-service appeal decisions no later than five days after the decision is made. Claimant and the Board of Trustees may agree to further extension of these time periods.

If the Board of Trustees requests, an in-person hearing will be held in which the Claimant and/or authorized representative will be asked to attend and present information and documentation in support of the appeal. Such a hearing will be scheduled only if the Board of Trustees cannot decide an appeal from the written submission. The hearing will occur within the time frames identified above and is an example of special circumstances.

Incomplete Claims

If the Claimant fails to follow the above-referenced procedures or does not provide sufficient information to decide an appeal, the Plan will notify the Claimant prior to the appeal date. The Claimant will have 45 days from receipt of the notification within which to provide the additional information. The Claimant and the Plan may agree to further extensions of this time period. All time periods for deciding an appeal mentioned above shall be tolled from the date on which notification of any extension(s) is sent to the Claimant until the date on which the Claimant responds to the request for additional material.

Notice of Appeal Decisions

All appeal decisions, whether adverse or not, will be provided to the Claimant in writing or by electronic notification. If the appeal is denied, in whole or in part, the notification will contain the following information:

1. the specific reason or reasons for the denial;
2. reference to the specific Plan provision(s) on which the denial is based;
3. a statement that Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claimant's claim for benefits.
4. a statement of the Claimant's right to bring an action under Section 502(a) of ERISA.
5. in the case of an appeal denial a statement that:
 - a. if an internal rule, guideline, protocol or other similar criterion was relied upon in the denial, then the internal rule, guideline, protocol or other criterion will be provided free of charge to the Claimant; or
 - b. if the denial was based on medical necessity or similar exclusion or limit, then explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, will be provided to the Claimant free of charge.

Appeal Standards

The Trustees' review of a Claimant's request for appeal will be a de novo review. This review will include a review and consideration of all information submitted by the Claimant without regard to whether such information was submitted or considered during the administrative claim review phase.

The Trustees will consult with a health care professional that has appropriate training and experience in the field of medicine if the decision under appeal was based in whole or in part on a medical judgment. The health care professional will be independent from any person who was involved in the initial administrative review phase.

The Trustees will provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim under appeal.

Any entity reviewing the Board of Trustees' decision may not consider evidence or facts that were not presented to the Board of Trustees on appeal. The Trustees have the sole power and discretion to construe any and all terms of the Plan, and any such construction shall be binding on all persons concerned to the fullest extent of the law.

Miscellaneous Benefit Claim and Appeal Procedures

The claim and appeal rights described herein cannot be assigned to any medical provider or other person or entity. Therefore, all benefit claims appeals and Section 502(a) actions shall be made by the Claimant, i.e., participant and/or beneficiary. A Claimant may authorize a representative, such as a medical provider with knowledge of the Claimant's condition, to participate in the benefit claim process or act on their behalf, however, the authorization must be made by the participant or the beneficiary in writing to Alicare Medical Management or the Administrative Office, as applicable (orally to Alicare Medical Management if it is an urgent care claim, unless the Claimant is unable to do so because of medical exigencies) and cannot be made via assignment by the Claimant to a medical provider or by a medical provider to a collection agency, etc.

The Benefit Claim and Appeal Procedures contained in this booklet are in compliance with ERISA Section 503 and the Department of Labor Regulations set forth at 29 CFR 2560-503.1, and as such are intended to be reasonable and offer a full and fair review process. Any omissions or oversights will be interpreted in accordance with the applicable law and its corresponding regulations.

YOUR ERISA RIGHTS

As a Participant in certain of the various Employee benefit plans described in this guide, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Administrative Office or at other specified locations, 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 Fund Administrator with the US Department of Labor, and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Fund Administrator, copies of all Plan documents and other Plan information. The Fund Administrator may make a reasonable charge for these copies.
- Receive a summary of the Plans' annual financial report. The Plan's Fund Administrator is required by law to furnish each Participant with a copy of such summary annual reports.

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Fund Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents form the Fund Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor Los Angeles Regional Office, 1055 East Colorado Boulevard, Suite 200, Pasadena, CA 91106-2341. The phone number for the Los Angeles Regional Office is **(626) 229-1000**. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at **(866) 275-7922**.

ERISA INFORMATION

1. Name of Plan and Plan Sponsor

The name of the Plan is the Riverside County Electrical Health and Welfare Trust Fund (“Plan”) – Active Plan.

The Plan Sponsor is:

**Board of Trustees
Riverside County Electrical Health and Welfare Trust Fund
2831 Camino Del Rio South, Suite 311
San Diego, CA 92108
(800) 736-0401**

2. Plan Identification Numbers

The taxpayer identification number assigned to the Plan by the Internal Revenue Service is: 94-6137248. The Plan number is 501-C.

3. Type of Welfare Plan and Funding Organization

The Plan is a collectively bargained, joint-trusted labor-management trust. A complete list of the employers and employer organizations sponsoring the Plan may be obtained upon written request to the Fund Administrator and is available for examination at the Fund Administrator’s office.

The Plan provides certain medical, prescription drug, dental, vision and accidental death and dismemberment benefits for Active Employees and their eligible dependents.

4. Organizations Through Which Benefits are Provided:

The carriers listed below provide fully insured benefits under the Plan:

The Hartford Group Insurance P.O. Box 2999 Hartford, CT 06104-2999	Life Insurance and Accidental Death and Dismemberment
Kaiser Permanente 393 East Walnut Street Pasadena, CA 91188	Prepaid medical benefits
Aetna 10370 Commerce Ctr. Dr. Ste 230 Rancho Cucamonga, CA 91730	Prepaid medical benefits

Delta Dental and Delta PMI 12898 Towne Center Drive Cerritos, CA 90703	Indemnity Dental and prepaid dental plans
Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670	Vision benefits

The Plan is self-funded (claims are paid directly from the assets of the Fund) for the benefits listed below. These carriers administer at least a portion of the benefits for the Plan, but do not insure or otherwise guarantee any of the benefits of the Plan.

PacifiCare Behavior Health 3100 Lake Center Drive Santa Ana, CA 92704	Mental health and substance abuse benefits for participants enrolled in the indemnity medical plan
Alicare Medical Management 8C Industrial Way Salem, NH 03079	Utilization review services for participants enrolled in the indemnity medical plan
Beech Street 255000 Commerce Center Dr. Lake Forest, CA 92630	Preferred Provider Organization for medical providers under the indemnity medical plan
Express Scripts 308 14 th Street Huntington Beach, CA 92648	Prescription drugs for participants enrolled in the indemnity medical plan

5. Type of Administration

The type of administration of this plan is Contract Administration.

6. Fund Administrator

The Fund is administered by the following third party administrator;

**Allied Administrators
2831 Camino Del Rio South, Suite 311
San Diego, CA 92108
(800) 736-0401**

7. Agent for Service of Legal Process

**Melissa Cook
Melissa W. Cook & Associates
3444 Camino del Rio North, Suite 106
San Diego, CA 92108**

Service of legal process may also be made upon the Fund Administrator or any Trustee

8. **Source of Plan Contributions**

Benefits are provided primarily from employer contributions determined as a result of Collective Bargaining. A self-payment may be required if the hours work are insufficient for coverage.

9. **Date Fiscal Year Ends**

The fiscal year for this Plan ends, each year, on January 31.

10. **Claims Procedures**

The Claims and Appeals Procedures are detailed beginning on page 79.

11. **Collective Bargaining Agreements**

Contributions to the Plan are made on behalf of each Employee in accordance with Collective Bargaining Agreements between the International Brotherhood of Electrical Local 440 and employers in the industry. The Administrative Office will provide you, upon request, with a copy of the applicable Collective Bargaining Agreement. You will be charged a reasonable amount for copying

12. **Trustees of the Plan**

The names, titles, and business address of the Trustees of the Plan as of January 1, 2008 are:

Labor Trustees

Robert Frost
International Brotherhood of Electrical
(IBEW) Local 440
1074 W La Cadena Ave
Riverside, CA 92501

Roger Roper
International Brotherhood of Electrical
(IBEW) Local 440
1074 W. La Cadena Ave.
Riverside, CA 92501

Employer Trustees

David Shankle
National Electrical Contractors
Association - NECA
Southern Sierras Chapter
P.O. Box 12149
San Bernardino, CA 92423

Rodney Anderson
Riverside County Electrical
Workers Health Fund
2831 Camino Del Rio South
Suite 311
San Diego, CA 92108

Glenn DeSoto
Riverside County Electrical
Workers Health Fund
2831 Camino Del Rio South
Suite 311
San Diego, CA 92108

PRIVACY OF PROTECTED HEALTH INFORMATION UNDER HIPAA

(Effective April 14, 2004)

The Plan will use and disclose protected health information (“PHI”) in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

PHI is defined as individually identifiable health information that is maintained or transmitted by this Plan in any form or medium (oral, written, or electronic). Individually identifiable health information is health information, including demographic information, that is created or received by a health care provider, employer, health care clearinghouse or this Plan and relates to the past, present or future physical or mental health condition of you or your eligible dependents, including payment information for the provision of health care. When held by this Plan, it also means information that either identifies you or your eligible dependents directly or indirectly, in that one has a reasonable belief that you or your eligible dependents can be identified using the information. For example, your name, address, birth date, marital status, Social Security Number, and choice of Health Plan would be considered PHI. Other examples are the amount of contributions paid by your employer for your coverage, or whether you are an active employee or Medicare enrollee.

The following uses and disclosures of PHI, and the corresponding rights and duties apply to you and your eligible dependents.

Permitted Uses and Disclosures of PHI

This Plan and its Business Associates will use and disclose PHI without your authorization for purposes of treatment, payment and health care operations, but only the minimum amount of PHI necessary to accomplish these activities. Treatment includes but is not limited to the provision, coordination or management of health care among health care providers or the referral of a patient from one health care provider to another. Payment includes but is not limited to actions concerning eligibility, coverage determinations, coordination of benefits, adjudication of health benefit claims (including appeals), determinations of cost-sharing amounts, utilization reviews, medical necessity reviews, preauthorization reviews, and billing and collection activities. Health care operations include but are not limited to performing quality assessment reviews, implementing disease management programs, reviewing the competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes legal services and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business planning programs, and other related administrative activities.

Required Uses and Disclosures of PHI

This Plan must disclose PHI to you upon request to access your own PHI, with limited exceptions, or to request an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of the U.S. Department of Health and Human Services (“HHS”) and its Office of Civil Rights (“OCR”) or other authorized government organizations to investigate or determine this Plan’s compliance with the Privacy Rule.

Agreed to Uses and Disclosures of PHI by You After an Opportunity to Agree or Disagree to the Use or Disclosure

This Plan will disclose PHI to family members, other relatives or close personal friends if the information is directly relevant to the family or friend’s involvement with your health care or payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected.

Allowed Uses and Disclosures of PHI for which Authorization or Opportunity to Object is Not Required

This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, worker’s compensation programs and correctional facilities. These uses and disclosures are more fully described in this Plan’s Privacy Policy Statement and Notice of Privacy Practices for Protected Health Information. Additional copies of these documents may be obtained from the Administrative Office.

Your Individual Rights

HIPAA and the Privacy Rule afford you the following rights:

You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a request. If this Plan agrees, it is bound by the restriction except when otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction.

You (or your personal representative) have the right to request to receive communications of PHI from this Plan either by alternative means or at alternative locations. This Plan may agree to accommodate any such request if it is reasonable. This Plan, however, must accommodate such requests if you clearly state that the disclosure of all or a part of the PHI could endanger you. You will be required to complete a request form to receive communications of PHI by alternative means or at alternative locations.

You (or your personal representative) have the right to request access to your PHI contained in a Designated Record Set, for inspection and copying, for as long as this Plan maintains the PHI. A Designated Record Set includes the medical billing records about you maintained by or for a covered health care provider, enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for this Plan, or other information used in whole or in part by or for this Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you are not in the Designated Record Set and therefore not subject to access. The right to access does not apply to psychotherapy notes or information compiled in anticipation of litigation. You must complete a request form to access PHI in a Designated Record Set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. This Plan may charge a reasonable fee for the costs of copying. If access to inspect and copy your PHI is denied, a written denial will be provided setting forth the basis for the denial, a description of how you may have the denial reviewed, if applicable, and a description of how you may file a complaint with this Plan or the HHS or its OCR.

You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a request form to amend PHI in a Designated Record Set. This Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You (or your personal representative) have the right to request an accounting of disclosures of PHI by this Plan. This Plan will provide such an accounting only for a six-year period starting from the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment or health care operations or made to you about your own PHI. Also, this Plan is not required to provide an accounting of disclosures pursuant to an authorization request or disclosures made prior to the compliance date of the Privacy Rule. You will be required to complete a request form to obtain an accounting of PHI disclosures by this Plan. The Fund will provide an accounting of disclosures within 60 days of the request. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written

statement of the reasons for the delay and the date by which the accounting will be provided. If more than one request for an accounting is made within a 12-month period, this Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Access by Personal Representatives to PHI

This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal representative with a limited health care power of attorney regarding a specific treatment, such as use of artificial life support, is your representative only with respect to PHI that relates to decisions concerning this treatment. The personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to take any action.

Proof of such authority may take the form of a notarized power of attorney for health care purposes (general, durable or health care power of attorney), a court order of appointment as your conservator or guardian, an individual who is the parent, guardian or other person acting in loco parentis with legal authority to make health care decisions on behalf of a minor child, or an executor of the estate, next of kin, or other family member on behalf of a decedent.

This Plan retains discretion to deny a personal representative access to PHI if this Plan reasonably believes that you have been or may be subjected to domestic violence, abuse, or neglect by the personal representative or that treating a person as your personal representative could endanger you. This also applies to personal representatives of minors. Also, there are limited circumstances under state and other applicable laws when the parent is not the personal representative with respect to a minor child's health care information.

This Plan's Duties

In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The Administrative Office has designated this group of employees to include Claims Adjustors, Claims File Clerks, Mail Clerks, Eligibility Certifiers, Supervisors and Managers. The employees described above may only have access to and use and disclose PHI for plan administration functions. A mechanism shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

This Plan is required by law to provide you with its Notice of Privacy Practices ("Notice") by April 14, 2004 and thereafter, upon request. Also, the Notice must be distributed by this Plan to new employees and dependents upon enrollment. You will be

advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

This Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. This minimum necessary standard, however, will not apply to disclosures to or requests by a health care provider for treatment purposes, disclosures made to you, uses or disclosures pursuant to your authorization, disclosures made to HHS or its OCR for enforcement purposes, uses or disclosures that are required by law, and uses or disclosures that are required for this Plan's compliance with HIPAA's Administration Simplification Rules.

Miscellaneous

This Plan may disclose de-identified health information. Health information is considered de-identified if it does not identify you and there is no reasonable basis to believe the information can be used to identify you, such as your name and Social Security Number.

This Plan may disclose summary health information to the Board of Trustees or a Business Associate. Summary health information is PHI which includes claims history and claims experience, and from which identifying information has been deleted in accordance with the Privacy Rule.

This Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages its use or purchase. However, this Plan may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided under the Plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.

The Board of Trustees' Duties

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have amended the Plan's Trust Agreement and signed a certification agreeing not to use or disclose your PHI other than as permitted by the Plan documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures

are more fully described in this Plan's Privacy Policy Statement, Notice of Privacy Practices for Protected Health Information, and Board of Trustees' Certificate. Additional copies of these documents can be obtained from the Administrative Office.

Complaints

If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer at the following address: Allied Administrators, 2831 Camino Del Rio South, Suite 311, San Diego, California 92108. A complaint may also be filed with the HHS or its OCR, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201.

All complaints must be in writing and filed within 180 days of the date you knew or should have known of the violation. This time limit can be waived if good cause is shown. This Plan will not retaliate against you for filing a complaint.

This booklet is a Summary Plan Description required by federal law. Of necessity, this booklet describes in general terms that Plans provided through the Trust. It is not to be considered a contract of insurance. All statements made in this booklet are subject to the complete terms of the Riverside County Electrical Health Plan.

All questions with respect to Plan participation, eligibility for benefits, or the nature and amount of benefits, or with respect to any matter of Trust Fund or Plan administration should be referred to the Administrative Office of the Trust Fund.

No representations made to a participant, Physician, Hospital or other medical provider concerning eligibility, entitlement to benefits or the amount of benefits payable are binding on the Trust Fund unless the representation is made in writing and made by the Board of Trustees or the Administrative Manager.

The only parties authorized to answer any questions concerning the Trust Fund and Plan are the Board of Trustees and the Administrative Manager. No participating employer, employer association, or labor organization, or any individual employed thereby, has any such authority.

Consultant:

**Rael & Letson
35 North Lake Avenue, Suite 810
Pasadena, CA 91101**

Administered by:

**Allied Administrators
2831 Camino Del Rio South, Suite 311
San Diego, CA 92108
(800) 736-0401**